Seventh National CAHPS User Group Meeting

March 8–9, 2001
Alexis Park
Las Vegas, NV

A meeting for employers, health care coalitions, health plans, Government agencies, and health information organizations

Sponsored by the Agency for Healthcare Research and Quality

Co-sponsored by the Health Care Financing Administration

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AGENDA

SEVENTH NATIONAL CAHPS USER GROUP MEETING—MARCH 8–9, 2001
ALEXIS PARK
LAS VEGAS, NEVADA

MARCH 8, 2001

TIME	SESSION/SPEAKER(S)
7.45-8.30 a.m Parthenon #2	**BREAKFAST**
8.30-9.20 a.m. Parthenon #4	Welcome*: Samantha Sheridan, Westat* Update on CAHPS Activities: Where Are We Now and Where Are We Headed, *Christine Crofton and Charles Darby, Agency for Healthcare Research and Quality (AHRQ)*
9.20-9.30 a.m. Parthenon #4	Review of Agenda, *Vasudha Narayanan, Westat*
9.30-10.45 a.m. Parthenon #4	CAHPS in Research and Policy Using the National CAHPS Benchmarking Database (NCBD) for Research, *Dale Shaller, Quality Measurement Advisory Service (QMAS)* Implications of Presenting Clinical Data with CAHPS Data to Consumers, *Diane Ebersberger, VHA, Inc.* Role of the National Quality Report, *Tom Reilly, AHRQ* *Moderator: Charles Darby, AHRQ*
10.45-11.00 a.m.	**BREAK**
POSTER SESSIONS will be open from 10.30 a.m. to 7.00 p.m. in Parthenon #2.	

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SEVENTH NATIONAL CAHPS USER GROUP MEETING—MARCH 8–9, 2001
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MARCH 8, 2001 (CONT.)

BREAK-OUT SESSIONS

	DEVELOPMENT & DESIGN TRACK ZEUS A	REPORTING TRACK ZEUS B	IMPLEMENTATION TRACK ZEUS C
11.00-12.15 p.m.	Children with Special Needs Survey *Christine Bethell, Foundation for Accountability; Joe Thompson, Arkansas Children's Hospital*	Designing Reports for Medicare Enrollees: Lessons Learned Results of an Evaluation of Medicare & You 2000, *Lauren McCormack, Research Triangle Institute (RTI)* Reporting Medicare Fee-for-Service CAHPS Results, *Elizabeth Jael, RTI* Designing Effective Medicare Plan Choice Documents, *Lauren Harris-Kojetin, RTI* *Moderator: Shula Bernard, RTI*	Using CAHPS results for Quality Improvement CAHPS as Quality Improvement Tool for Medicare PROs, *Paul Cleary, Harvard Medical School* Quality Improvement in Managed Care Organizations, *Dennis Scanlon, Pennsylvania State University*
12.15-2.00 p.m. Parthenon #1	**LUNCH** Key Note Address: Role of media in reporting health care quality information to consumers *Mason Essif, Newsweek Productions; Jonathan Hamilton, National Public Radio (NPR), Glenn Howatt, Minneapolis Star Tribune* *Moderator: Charles Darby (AHRQ)*		
2.00-3.15 p.m.	Practical Applications of Research on Cultural Competency How Do Different Language Groups React to CAHPS Item Wording, *Jeanne McGee, McGee & Evers Consulting* What Survey Methods Work Well Among Spanish Speakers, *Leo Morales, UCLA School of Medicine* Partnerships Among Community-based Organizations and Health Plans to Deliver Appropriate Care, *Dennis McIntyre, KPMG Consulting* How Can State Programs and Health Plans Make Best Use of Research on Cultural Competency, *Lorraine Brown, Managed Risk Medical Insurance Board (MRMIB)* *Moderator: Samantha Sheridan, Westat*	Reports Distribution Strategies Using Interactive Computerized Reports, *Mary Uyeda, Washington Health Care Authority* An Evaluation of Distribution Strategies for Paper Reports, *Cheryl DeMars, Alliance* *Moderator: Elizabeth Hoy, Westat*	Implementing the Children with Special Needs Survey Implementing the Special Needs Survey in the Medicaid and CHIP Programs in Georgia, *Jennifer Edwards, Georgia Health Policy Center* Using the Special Needs Survey as an Eligibility Screener in North Carolina, *Terri Bruner, North Carolina Division of Medical Assistance* *Responder: Nora Wells, Family Voices*
3.15-3.30 p.m.	**BREAK**		

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MARCH 8, 2001 (CONT.)

BREAK-OUT SESSIONS (CONT.)

	DEVELOPMENT & DESIGN TRACK ZEUS A	REPORTING TRACK ZEUS B	IMPLEMENTATION TRACK ZEUS C
3.30-4.45 p.m.	Experience with Care and Health Outcomes (ECHO) Survey for Collecting Consumer Experience with Their Behavioral Health Care, *Jim Shaul, Harvard Medical School*	Workshop on Designing Culturally Sensitive Consumer Reports, *Jeanne McGee, McGee & Evers Consulting*	Discussion Group: NCBD User Group *Facilitator: Dale Shaller, QMAS* *Karen Onstad, QMAS*
4.45-7.00 p.m. Parthenon #2	**POSTER SESSION**		
5.30-7.00 p.m. Parthenon #2	**RECEPTION**		

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TIME	SESSION/SPEAKER(S)
7.45-8.30 a.m. Parthenon #2	**BREAKFAST**
8.30-8.45 a.m. Parthenon #4	Review of Day 1 and Overview of Day 2 Agenda, *Charles Darby, AHRQ*
8.45-9.45 a.m. Parthenon #4	Coordination of Accreditation Requirements, *Jim Bost, National Committee for Quality Assurance (NCQA); Liza Greenberg, URAC* *Moderator: Darendia McCauley, Oklahoma Health Care Authority*
9.45-10.45 a.m. Parthenon #4	HCFA's Medicare CAHPS Activities—An Update: *Liz Goldstein, Health Care Financing Administration (HCFA)*
10.45-11.00 a.m.	**BREAK**
POSTER SESSIONS will be open from 7.45 a.m. to 3.30 p.m. in Parthenon #2	

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MARCH 9, 2001 (CONT.)

BREAK-OUT SESSIONS

	DEVELOPMENT & DESIGN TRACK ZEUS A	REPORTING TRACK ZEUS B	IMPLEMENTATION TRACK ZEUS C
11.00-12.15 p.m.	Group Provider CAHPS Survey, *Ron Hays, RAND/UCLA; Loel Solomon, Harvard Medical School*	Development of a Short Form Quality Report for Medicaid Enrollees Results of Consumer Testing in Massachusetts and Washington, *Fiona Smith, The Picker Institute* Experience with Short Form Reports in Washington, *Becky McAninch-Dake, Washington State Medical Assistance Administration* Experience with Short Form Reports in Oklahoma, *Darendia McCauley, Oklahoma Health Care Authority* *Moderator: Elizabeth Hoy, Westat*	Implementing CAHPS through Coalitions Models for Coalition Initiatives in Quality Measurement, *Dale Shaller, QMAS* Characteristics of Effective Coalitions, *Steve Garfinkel, RTI* MA Health Quality Partnership, *Kathy Coltin, Alliance for Community Health Plans* *Moderator: Samantha Sheridan, Westat*
12.15-1.15 p.m. Parthenon #1	**LUNCH**		
1.15-2.30 p.m.	Adapting CAHPS Medicaid Survey to Other Contexts Adapting CAHPS Medicaid to the ARKids First Program, *Heather Ables, Medicaid Managed Care Services* Adapting CAHPS Medicaid to the SCHIP program in California, *Lorraine Brown, MRMIB* *Moderator: Julie Brown, RAND*	Discussion Group: Reporting to Hard-to-Reach Audiences *Facilitator: Jeanne McGee, McGee & Evers Consulting*	Implementing Consumer Assessment Surveys at the Provider Level Implementation at the Medical Group Level in California, *Cheryl Damberg, Pacific Business Group on Health* Implementation at the Care System and Clinic Level in Minnesota, *Walter Suarez, Minnesota Health Data Institute* Implementation at the Physician Level in Portland and Cincinnati, *Mike Hays, National Research Council* *Moderator: Dale Shaller, QMAS*
2.30-2.45 p.m.	**BREAK**		

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MARCH 9, 2001 (CONT.)

BREAK-OUT SESSIONS (CONT.)

	DEVELOPMENT & DESIGN TRACK	REPORTING TRACK	IMPLEMENTATION TRACK
	ZEUS A	ZEUS B	ZEUS C
2.45-4.00 p.m.	Discussion Group: Areas of Expansion for CAHPS *Facilitator: Charles Darby, AHRQ*	Reporting CAHPS Results for Children with Special Needs What Do Families Want and Need to Know? *Nora Wells, Family Voices* Washington State Living with Illness (LWI) Reporting Measures, *Alice Lind, Washington State Medical Assistance Administration* *Moderator: Elizabeth Hoy, Westat*	Using CAHPS to Evaluate Delivery Systems Evaluating Introduction of Managed Care to the Medicaid SSI Program in Oklahoma, *Darendia McCauley, Oklahoma Health Care Authority* Evaluating Differences Between HMO/POS and PPO Product Lines in Carefirst Blue Cross Blue Shield, *Jim Borton, Carefirst Blue Cross Blue Shield* Evaluating the Health Care Residents of Delaware Receive, *Eric Jacobson, University of Delaware* *Moderator: Jim Lubalin, RTI/Lubalin Consulting*
4.00 p.m.	**ADJOURN**		

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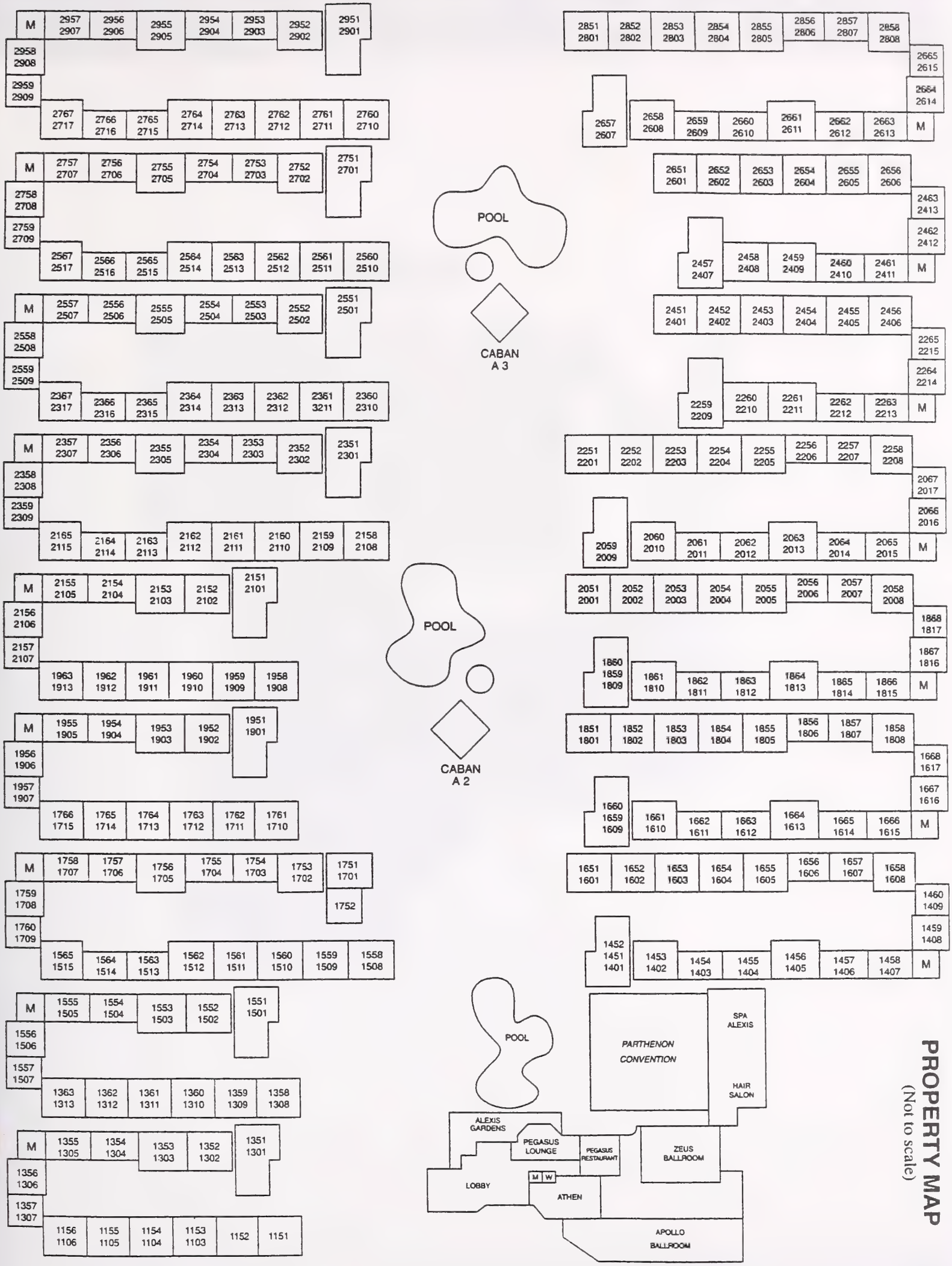
POSTER SESSIONS

TOPIC	AUTHOR
Dental CAHPS	Julie Brown, RAND
Chiropractic CAHPS	Ron Hays, RAND/UCLA
Analysis of Minnesota Medicaid Data by Race	Walter Suarez, Minnesota Health Data Institute
The Alliance and Employers' Health Care Cooperative CAHPS Study in Wisconsin	Tim Nanneman, Roper Starch and Cheryl DeMars, Alliance
Consumer Satisfaction under FFS Medicaid and Medicaid Managed Care in El Paso	Rena Manning, Texas Health Quality Alliance
Differential Item Functioning: Potential Population Differences Within the CAHPS Fee-for-Service Field Test	Carla Bann and Sheri Fehnel, RTI
New Mexico Medicaid Study	Tim Nanneman, Roper Starch and Becky Schwarz, New Mexico Human Services Department
National CAHPS Benchmarking Databases (NCBD)	Westat, QMAS, Picker
The Impact of CAHPS Survey Data on an Employed Population	Nancy Berkman, RTI
Using CAHPS to compare plans: What Do the Stars Tell Us?	Scott Schleffer, RTI and Vince Iannacchione, RTI
Satisfaction in the Aging, Blind, and Disabled Medicaid Population Pre and Post Transition into Managed Care	Terry Winston, Oklahoma Foundation for Medical Quality, Inc.

DEMONSTRATIONS

TOPIC	PRESENTED BY
Health Cost Calculator: A Web-based Tool that Helps Consumers Estimate Total Out-of-Pocket Health Expenses	Mark Spranca, RAND
A Tool for Administering, Scoring, and Reporting CAHPS Survey Results	Troy Sherrill, Applied Survey Knowledge
talkingquality.gov: A Resource to Help Sponsors Develop Health Information Materials for Consumers	Kerri Yoder, Westat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ALEXIS GARDENS
PEGASUS LOUNGE
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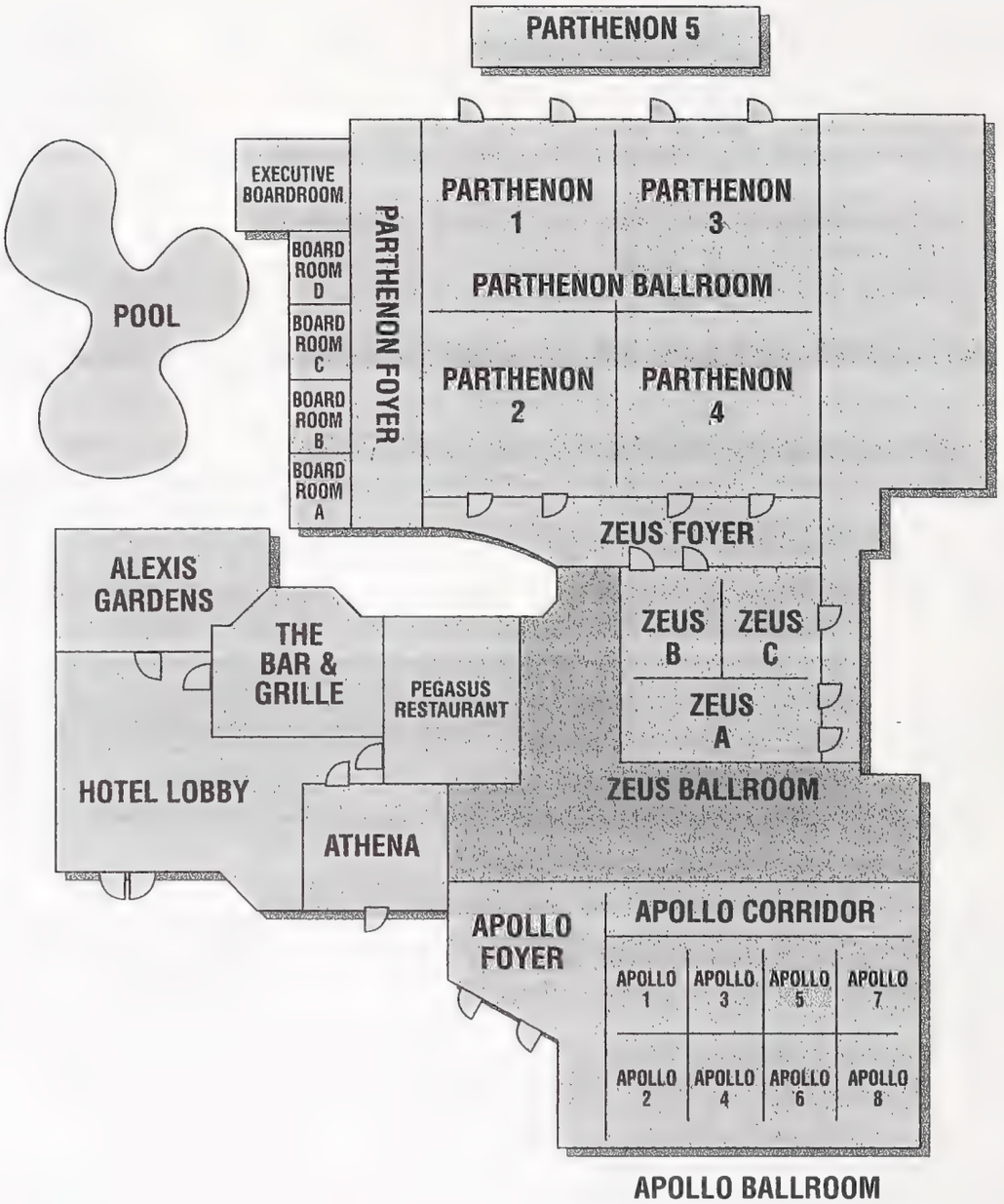
APOLLO BALLROOM
PROPERTY MAP
(Not to scale)

Meeting and Convention Facilities



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Clinical Quality Data and CAHPS: An Opportunity?

Seventh National CAHPS User Group Meeting
March 8, 2001
Diane Ebersberger, VHA, Inc.

Overview

- 1998 Environmental Assessment - "Unprecedented demand for standardized information on consumers' experience with their health care" _ Paul Cleary
- Recent consumer research suggesting expanded consumer definitions of quality and demand for clinical information
- Implications/opportunities for CAHPS

VHA Consumer Research

- Completed in the fall of 2000
- 500+ experienced health care users who generally seek out health care information
- Explored current attitudes about health care quality and provider selection drivers
- Tested response to the concept of evidence-based medicine (EBM) and evidence-based comparative clinical performance information

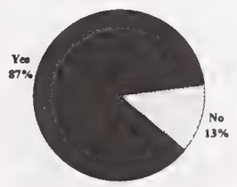
Major CAHPS-Relevant Findings

- Consumer definition of quality has expanded to include clinical performance as an important driver of provider choice.
- Concepts of EBM and use of process measures for comparing clinical performance are understood and embraced.
- Evidence-based process measures in the hands of consumers may drive clinical improvement at the level of the doctor-patient relationship.
- Doctors are responsible for quality

Clinical Performance
Process measures
Doctors equal Quality (or NO Q)

Consumers Are Highly Aware of Medical Errors

Have you read, seen or heard about any information regarding reports on medical errors in health care.



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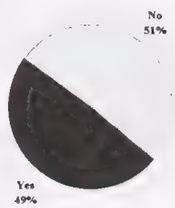
Many Consumers Have Had Poor Experiences

In the past 3 years, have you or your family had bad experiences with a doctor or hospital



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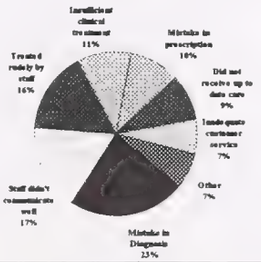
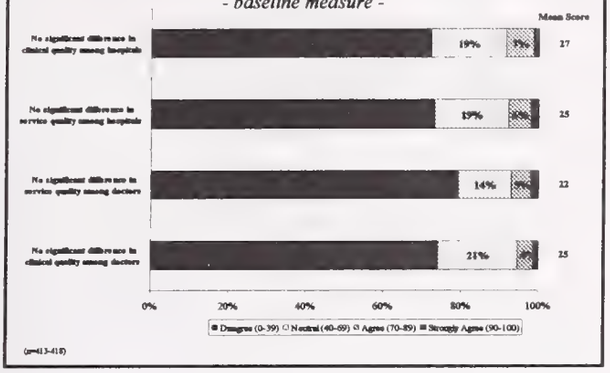
Primary cause of most significant bad experience



Consumers Recognize There Are Differences In Quality

Please indicate the extent to which you agree or disagree with the following statements.

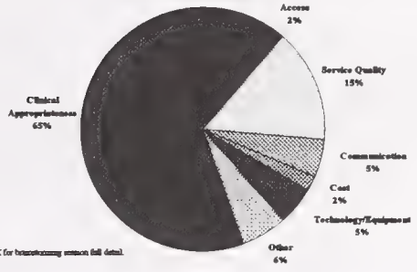
- baseline measure -



(n=413-418)

Clinical Quality Is Central to Consumers' Definition of Health Care Quality

- Brainstorming Session -

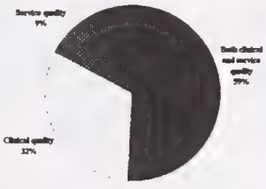


*Refer to Appendix X for brainstorming session full detail.
n=414

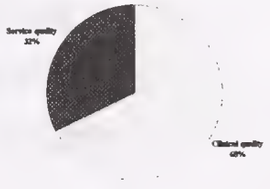
Clinical Quality Carries More Weight in Decision Making than Service Quality

- baseline measure -

Which of the following carries more weight in decision-making process



If you had to choose Between Clinical and Service Quality, which carries more weight in the decision-making process



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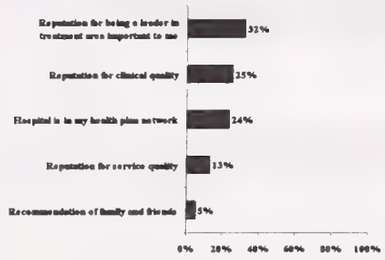
Clinical Quality - important

Characteristics Important When Choosing a Hospital

- baseline measure -



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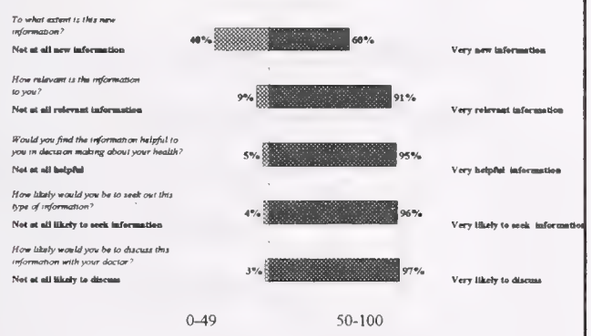
Concepts of EBM were understood, embraced and influential.

- Consumers were presented with the concept of evidence based medicine
- Asked questions about newness and relevance of the information
- Asked about helpfulness of information and likelihood to seek and use the information
- Asked whether having EBM performance data would influence choice

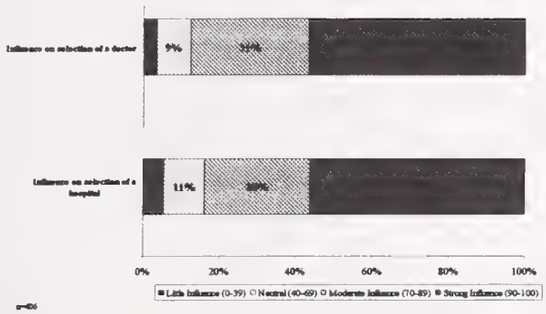
Evidence-Based Medicine

Concept A: Evidence-based Treatment Plans


To what extent is this new information?
Not at all new information
40%
60%
Very new information
How relevant is the information to you?
Not at all relevant information
9%
91%
Very relevant information
Would you find the information helpful to you in decision making about your health?
Not at all helpful
5%
95%
Very helpful information
How likely would you be to seek out this type of information?
Not at all likely to seek information
4%
96%
Very likely to seek information
How likely would you be to discuss this information with your doctor?
Not at all likely to discuss
3%
97%
Very likely to discuss
0-49
50-100

n=415

Concept B: Cardiac Patient Treatment Plans



n=406

Measuring Treatment Quality

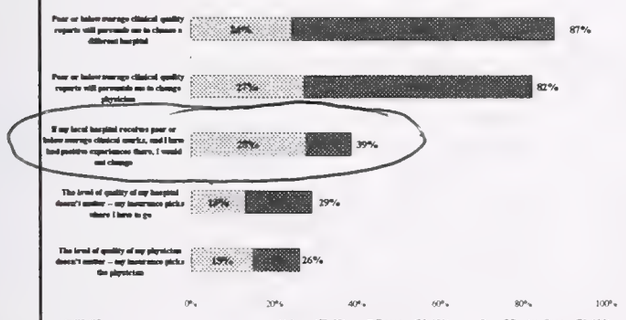
Monitoring Use of Beta Blockers in Cardiac Care

Research shows that eligible patients who take beta blockers after a heart attack are less likely to have another attack. The following table illustrates the percentage of eligible patients that receive beta blockers after a heart attack for various hospitals. If the percentage is high, the hospital is doing a good job of attempting to prevent future attacks.

Concept C

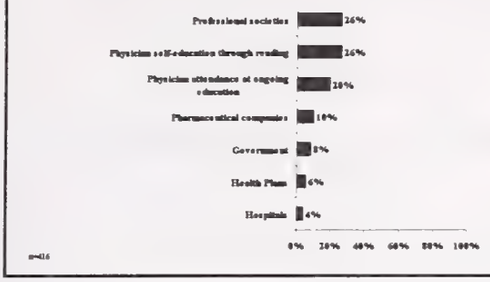
Clinical Quality Reports Influence Decision Making

Please indicate the extent to which you agree or disagree with the following statements.


Poor or below average clinical quality reports will persuade me to choose a different hospital
87%
Poor or below average clinical quality reports will persuade me to change physician
82%
If my local hospital receives poor or below average clinical marks, and I have had positive experiences there, I would not change
39%
The level of quality of my hospital doesn't matter – my insurance picks where I have to go
29%
The level of quality of my physician doesn't matter – my insurance picks the physician
26%
0%
20%
40%
60%
80%
100%
Agree (70-89)
Disagree (90-100)
Overall Positive Scores (70-100)

n=413-417

Primary Source for Providing Doctors with the Most Up-To-Date Treatments



Opportunities

- Apply CAHPS-like rigor, care, intellectual resources and enthusiasm to development of clinical information for consumers
- Link clinical and CAHPS experiential information to provide consumers with a multi-dimensional assessment of quality
- Consider focusing on evidence-based process measures
- Continue development of provider level information

Using NCBD Data for Research

Dale Shaller
Program Director, QMAS

Seventh National CAHPS User Group Meeting
March 8, 2001

Two Major NCBD Applications

- **BENCHMARKING:** Facilitate sponsor comparisons of CAHPS survey results to support quality measurement and improvement
- **RESEARCH:** Provide authorized access to CAHPS data to support health services and policy research

NCBD Management and Funding

- NCBD is administered as a partnership between QMAS, Picker Institute, and Westat
- Advice and counsel is provided by an NCBD Advisory Group
- Phase I (1998) funding through Hartford Foundation grant
- Phase II-IV (1999-2001) funding through AHRQ contract with Westat

Participation in the NCBD

- All sponsors of CAHPS surveys that are administered independently according to CAHPS specifications are invited to participate
- Sponsors include:
  - Public and private employers
  - Medicaid agencies and CHIP programs
  - Medicare
  - Health plans

NCBD Products and Services

- Core Products and Services
  - Sponsor Reports and Support Activities
  - Annual Report
  - Access to Data Files for Research
  - Input to AHRQ National Quality Report
- Secondary Products and Services
  - Custom Analysis and Reports
  - Consulting and Technical Assistance

NCBD Database Components

- CAHPS Survey Response Data
- Survey Administration Data
- Health Plan and Provider Characteristics Data

2000 Database Composition

	Adult Population		Child Population	
Population Sector	Health Plans	Responses	Health Plan	Responses
Commercial	282	145,369	8	2,760
Medicaid	156	49,327	138	41,504
Medicare	367	166,072	–	--
Total	805	360,768	147	44,264

2000 Response Rates by Sector

Population Sector	Adult Population	Child Population
Commercial	48.02 %	41.67 %
Medicaid	37.56 %	40.05 %
Medicare Managed Care	82.0 %	--

NCBD Data Access Process

- Applicant submits a written proposal to the NCBD Executive Research Committee (ERC)
- Proposal specifies:
  - Principal researcher
  - Research questions and study design
  - Data sets requested
  - Proposed products
- Data release agreement signed upon ERC approval

Selected Research Projects

- Hays (RAND): Impact of race/ethnicity
- Thompson (AHRQ): Medicaid child analyses
- Sangl (AHRQ): Adult versus child results
- Zaslavsky (Harvard): Impact of plan characteristics
- Manocchia (HAR): Impact of HMO tax status

Example: Impact of Race/Ethnicity

- Morales et al (RAND):
  - Whites give more positive reports than other racial/ethnic groups
  - Differences between groups are less for ratings
- Sangl and Lurie:
  - Blacks score higher on 8 of 9 core measures
  - Large differences in access between groups
  - Significant differences between plans in racial/ethnic disparities

what are core measures and why

Example: Adult vs. Child Survey Results

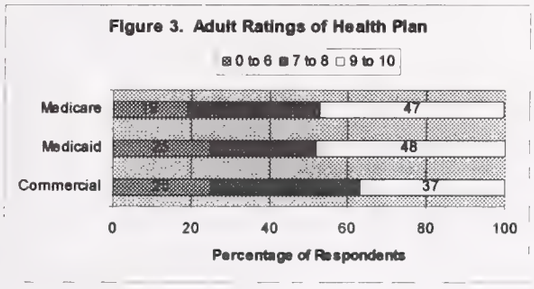
- Sangl et al (AHRQ):
  - Child scores are higher than adults
    - Medicaid: All 4 ratings and 5 composites
    - Commercial: All except specialist rating and customer service and getting care without long wait composites
  - Differences exist between adult and child ratings within the same plan
  - Better health status is strongly correlated with higher ratings for both adult and children

NCBD Annual Report Findings

- The majority of plan enrollees rate their health plans and medical care highly
- Differences exist in ratings and reports across commercial, Medicaid, and Medicare respondents
- Large differences exist in plan-specific results

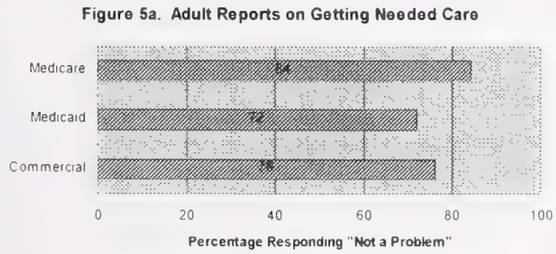
Three major messages to be conveyed in annual report.

Cross-Sector Comparisons: Adult Ratings of Health Plan



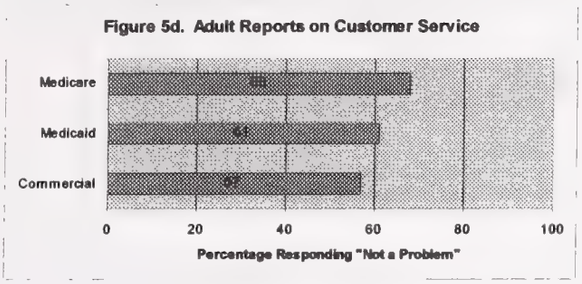
Focus on top / Bottom end or analyze the mix?

Cross-Sector Comparisons: Adult Reports on Getting Needed Care

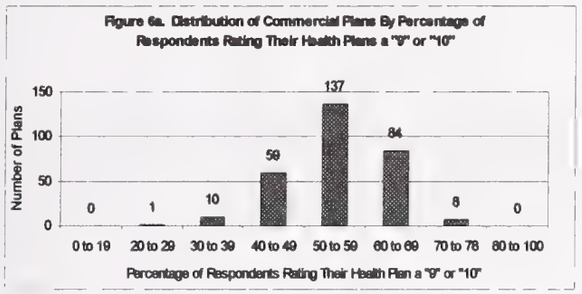


Medicare is always the most positive, correlations between reports and correlations

Cross-Sector Comparisons: Adult Reports on Customer Service



Variation in Scores by Plan



Next Steps

- Expand database to include new CAHPS derived surveys, e.g.:
  - Group CAHPS
  - Behavioral CAHPS
  - Children with Special Health Care Needs
- Provide links to other data sets to enhance research value
- Focus on use of NCBD data and reports for improvement

National Trends
National Quality Reports
Improve care and quality reports

For More Information

- NCBD Web Page: ncbd.cahps.org
- SUN Helpline: 1-800-492-9261
- QMAS: 651-430-0759
- Picker: 617-667-2388

NATIONAL CAHPS® BENCHMARKING DATABASE

PURPOSE OF THE NCBD

The primary purpose of the National CAHPS® Benchmarking Database (NCBD) is to facilitate comparisons of Consumer Assessment of Health Plans (CAHPS®) survey results among various types of CAHPS survey sponsors, including Medicaid agencies, public and private employers, and individual health plans. These comparisons are intended to provide both purchasers and health plans with benchmarking information useful for evaluating and improving performance as measured by the CAHPS survey. The NCBD also offers an important source of primary data for conducting specialized research that will enable improvements in future survey design and a better understanding of health plan and enrollee characteristics that influence performance.

ADMINISTRATION OF THE NCBD

The NCBD is sponsored by the Agency for Healthcare Research and Quality (AHRQ), formerly known as AHCPR, and administered through a partnership between the Quality Measurement Advisory Service (QMAS), The Picker Institute, and Westat. A formal NCBD Advisory Group, composed of representatives from survey sponsor organizations and other groups with an interest in the NCBD, has been established to provide oversight and direction for the project.

PARTICIPATION IN THE NCBD

All sponsors of CAHPS surveys that are administered independently according to CAHPS specifications are invited to participate in the NCBD. Survey sponsors include public and private purchasers (employers, state Medicaid agencies, coalitions) and individual health plans.

NCBD COMPONENTS

The NCBD is designed to include three major data sets:

1. CAHPS Survey Response Data: The core of the NCBD is composed of CAHPS survey data, submitted at the individual respondent level by participating sponsors according to specifications provided by the NCBD project. These data include all information from the CAHPS survey, except for information identifying respondent names, addresses, telephone numbers, and member ID numbers.

2. Survey Administration Data: Information regarding survey administration is also included, such as mode of administration, dates of survey completion, response rates, data files corresponding to non-respondents, survey vendor information, etc.

3. Health Plan and Provider Descriptive Data: In addition to the survey data, the database includes descriptive information about each health plan or provider group included in the survey data submitted in order to help users interpret the CAHPS data.

The NCBD includes no data identifying individual respondents. The confidentiality of individual respondent information will be maintained at all times.

NCBD Products and Services

Three major products and services are available to participants in the NCBD:

- Standard Sponsor Reports: A standard sponsor-specific Benchmark Report is provided to each participating sponsor comparing their own survey results to appropriate benchmarks derived from the NCBD. Comparisons include national averages by population sector and the 90th percentile score for CAHPS results.

- Custom Analysis and Reports: Customized analyses and reports for participating sponsors will be produced on a fee-for-service basis as time and resources permit.

- Authorized Access to Data Files: All sponsors participating in the NCBD will have access to their own data. Access by other NCBD participants to sponsor-specific data files will be provided only upon the explicit authorization of the sponsor whose data files are requested. Aggregate or specialized subsets of the NCBD data files may be provided to qualified researchers at charge, according to guidelines developed and approved by the NCBD Advisory Group.

Funding and Participation Fees

The initial Phase One costs of developing and operating the NCBD (starting in 1998) have been covered by QMAS with grant funds provided by the John A. Hartford Foundation. This foundation grant enabled survey sponsors to participate in Phase One at no cost. Phase Two of the NCBD (1999) was funded through contract funding provided by the Agency for Healthcare Research and Quality (AHRQ), allowing sponsors to participate at no cost with adherence to data submission guidelines.

Phase IV of the NCBD (2001) will be supported through continued contract funding from AHRQ. This funding will again allow us to waive participation fees in 2001 for the first 100 sponsors, provided that their data are submitted according to NCBD data specifications and submission deadlines.

Participating sponsors will receive a standard sponsor-specific Benchmark Report at no cost. Additional reports will be available at a cost of $100 per report. A flat fee of $1,000 will be assessed to each sponsor submitting data that requires significant reformatting. A separate fee schedule will be developed to cover the costs of custom analyses, technical assistance, and for compiling data files in response to authorized requests.

For Further Information

Further information about the NCBD can be obtained from the NCBD Web site located at: http://ncbd.cahps.org. If you have any questions please call Dale Shaller, NCBD Managing Director, at 651-430-0759 or call the CAHPS Helpline at 1-800-492-9261.

ACCESS TO NCBD DATA FILES

The National CAHPS® Benchmarking Database (NCBD) was created to facilitate comparisons of Consumer Assessment of Health Plans Study (CAHPS®) results among different CAHPS survey sponsors, including public and private employers, Medicaid agencies, and individual health plans. The NCBD is sponsored by the Agency for Health Care Policy and Research and administered by the Quality Measurement Advisory Service in partnership with The Picker Institute and Westat.

All sponsors of CAHPS surveys that are administered according to CAHPS specifications are invited to participate in the NCBD. The NCBD includes three data sets: 1) CAHPS Survey Response Data; 2) Survey Administration Data; and 3) Health Plan and Provider Descriptive Data. The first data sets includes the CAHPS survey data, submitted at the individual respondent level by participating sponsors according to NCBD project specifications. These data include information from the survey and do not include information identifying respondent names, addresses, telephone numbers, or member ID numbers. A major tenet of the NCBD is to "include no data identifying individual respondents." The second data set includes information about survey administration such as mode of administration, response rates, and dates of survey completion. The third file includes descriptive information about each health plan or provider group surveyed.

Researchers interested in obtaining data from the NCBD must submit a written request containing the following information:

- The name, title and organizational affiliation of the individual(s) who will be using the data.
- A brief (less than one page) description of the research question(s) to be addressed and the analyses to be conducted.
- The time period for which access is requested. (Note: If different analyses are of interest at a later date, the access request must be updated and approved.)
- The specific data files requested (e.g., commercial, Medicaid, adult, children, CAHPS version, survey time period, etc.) and the specific substantive items that will be used in the analyses (e.g., respondent age, race/ethnicity, etc.).
- A description of products that will result from the research (number and kinds of articles, books, professional papers, teaching materials, etc.).

All requests for access to NCBD data files are reviewed and acted on by the NCBD Executive Research Committee. Upon approval, a data release agreement must be signed committing the researcher to specific procedures for safeguarding the confidentiality of the data. The agreement also specifies a statement to be used to acknowledge the NCBD as a data source in published analyses.

Further information about the NCBD and access to NCBD data files can be obtained from the NCBD Web site located at: http://ncbd.cahps.org. If you have any questions please call Kathy Coltin, NCBD Operations Director, at 617-667-8613.

NATIONAL CAHPS® BENCHMARKING DATABASE

SUMMARY AND CURRENT STATUS OF NCBD RESEARCH PROJECTS

February 2001

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Impact of Race/Ethnicity on Consumer Assessments of Health Care

Principal Researcher: Ron Hays, PhD

Brief Project Description: This analysis will address the following specific research questions:

- Do consumer reports and ratings of health plans vary by race/ethnicity?
- Do the psychometric properties of the consumer reports and ratings of health plans differ by race/ethnicity?
- Are differences in reliability of measurement explained or accounted for by educational attainment?
- Are differences in consumer reports and ratings of health plans evident in both the private sector and in the Medicaid population and for adult versus child surveys?

***Timeframe*:** Access to CAHPS 1.0 data approved from April 1999 through February 2000. Access to CAHPS 2.0 data approved through February 2001.

Current Status:

The following articles have been accepted for publication in *Health Services Research* and are currently in press:

- "Differences in CAHPS® Adult Survey Ratings and Reports by Race and Ethnicity: An Analysis of the National CAHPS® Benchmarking Data 1.0", Leo S. Morales, Marc N. Elliott, Robert Weech-Maldonado, Karen L. Spritzer, and Ron D. Hays

- "Racial and Ethnic Differences in Parents' Assessments of Pediatric Care in Medicaid Managed Care", Robert Weech-Maldonado, Leo S. Morales, Karen Spritzer, Marc Elliott, and Ron D. Hays

- "Case-mix Adjustment of the National CAHPS® Benchmarking Data 1.0: A Violation of Model Assumptions?" Marc N. Elliott, Richard Swartz, John Adams, Karen L. Spritzer, and Ron D. Hays

The following article has been accepted for publication in *Psychological Assessment* and is currently in press:

- "Confirmatory Factor Analysis of the Consumer Assessment of Health Plans Study (CAHPS®) 1.0 Core Survey", Grant N. Marshall, Leo S. Morales, Marc Elliott, Karen Spritzer, and Ron D. Hays

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Descriptive Results from Parents' Experience of Health Care for Their Children

Principal Researcher: Joseph W. Thompson, MD, MPH

Brief Project Description: This study will examine results obtained from surveys of parents about their experiences in achieving health care for their children. These results will be obtained from available information from NCBD and will constitute a convenience sample of submitted results for children in both Medicaid and commercial populations. Three stages of analyses are anticipated (and are determined by (1) data availability; and (2) dissemination opportunities):

- Stage 1: Descriptive summary of sponsor-specific and/or health plan-specific results.
- Stage II: Respondent-level analyses of parent-reported experiences in achieving health care for their children.
- Stage III: CAHPS 2.0 assessment of Medicaid and Commercial 1999 Results.

Timeframe: Access to CAHPS 1.0 data approved from June 1999 through May 2000 for a 12-month period with renewal requests for long-term trend analyses anticipated.

Current Status: Selected study findings were presented at the 5th National CAHPS User Group Meeting in October 1999. Two abstracts have been accepted at the Pediatric Academic Societies Annual Meeting in April 2001, with manuscripts to follow.

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Psychometric Properties of CAHPS® 2.0 Reporting Composites

Principal Researcher: J. Lee Hargraves, PhD

Brief Description: This study will evaluate the reliability and validity of the CAHPS® 2.0 reporting composites. Adult and child data from the NCBD in Medicaid and commercial populations will be analyzed. We propose to examine each of the following research issues:

- Internal consistency reliability of the CAHPS® 2.0 composites will be estimated with correlations between items and composites as well as Cronbach's coefficient alpha.
- Item discrimination across composites will be evaluated by comparing correlates of item-scale correlations for hypothesized scales (composites) versus correlations with other scales.
- Plan-level reliability of the composites and global ratings will be computed by partitioning between and within plan variance using ANOVA models. We will determine the number of respondents needed to obtain reliable estimates at the plan level.
- Construct validity of the reporting composites will be estimated by comparing a-priori hypotheses with actual correlations between composites and the global ratings of personal doctors, specialists, all health care, and health plans. In addition, we will estimate the multivariate associations of the five CAHPS® 2.0 composites with global rating items using linear models.
- We will evaluate the underlying dimensionality of the CAHPS® reporting items using exploratory and confirmatory factor analyses.

Timeframe: Access to CAHPS 2.0 data approved for a 12-month period from date of receipt.

Current Status: A draft paper on research findings has been completed and is currently in review by members of the CAHPS Consortium.

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Application of Probabilistic Conjoint Measurement (PCM) Models to CAHPS®

Principal Researcher: William P. Fisher, Jr., PhD

Brief Description: The proposed research follows up on a previous AHRQ funding proposal (1R01 HS10186-01) and like its predecessor is intended to demonstrate the potential that Probabilistic Conjoint Measurement (PCM) models offer for measuring health-related variables with a rigor and convenience equivalent to the measurement of physical variables. Measurement of this kind is required for creating the common currencies needed for exchanging quantitative values representing more and less health. Given the ostensible goal of health care reform, to pay for health and not services, the calibration of universally-accepted reference standards for health-related variables ought to be in great demand. Five studies will be conducted over a period of six months with the aim of demonstrating PCM's advantages for research employing surveys and Likert rating scales in health care, using AHRQ's Consumer Assessment of Health Plans Study (CAHPS) data. Results of the first study show that the CAHPS quality of care questions produce data meeting the requirements of fundamental measurement, as specified in a PCM rating scale model. A second study shows that the same quality of care construct emerges from analyses of variously-selected and -sized subsamples of cases, as shown by similar item difficulty orders across the samples. A third study suggests that the same quality of care construct emerges from both these CAHPS data and the Medical Expenditure Panel Survey (MEPS) quality of care survey data. Two additional studies are in progress, as are recommendations for improvements to quality of care measurement.

Timeframe: Access to CAHPS 1.0 data approved through June 2000.

Current Status: Research results have been presented as follows:

1. Fisher, William P., George Karabatos. 2000. Making the case for fundamental measurement with MEPS/CAHPS quality of care data: From concrete counts of survey responses to abstract measures of health care quality. Third International Outcome Measurement Conference, Rehabilitation Institute of Chicago, June.

2. Fisher, William P., George Karabatsos, John Ware. 2000. Fundamental measurement of quality of care: Results from the MEPS and the CAHPS. (Four-paper symposium w/ discussant, Session 4083.0) American Public Health Association, Boston, November.

Contact Information:

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wfishe@lsuhsc.edu

Analysis of Factors Influencing Variations in CAHPS® Scores

Principal Researcher: Alan Zaslavsky, PhD

Brief Description: This project will include the following four analyses of CAHPS 2.0 survey data:

- Analysis of CAHPS 2.0 data for an employed population to determine a small set of dimensions describing the between-plan variation on the CAHPS report items.
- Analysis to determine how scale transformations or collapsing of categories might best be applied to improve between-plan discrimination.
- Analysis of amount of variation contributed by different geographic levels (region, MSA and plan) to plan-level CAHPS in a commercial data set.
- Analysis of relationships between CAHPS scores and plan characteristics (including tax status, national versus local ownership, size) and benefit design.

Timeframe: Access to CAHPS 2.0 data approved through April 2001.

Current Status: Several papers on research findings have been drafted and are under review prior to submission for publication.

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The Impact of For-Profit, Managed Care Firms on Patient Experiences: Results from the National CAHPS® Benchmarking Database

Principal Researcher: Michael Manocchia, PhD

Brief Description: To compare the quality-of-care perceived by patients enrolled in managed care for investor-owned and not-for-profit HMOs based on the CAHPS® 2.0 survey.

Timeframe: Access to CAHPS 2.0 data approved through January 2001

Current Status: Study is still in progress.

Contact Information:

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Comparison of TRICARE and NCBD Data on Common CAHPS® Items

Principal Researcher: Peter H. Stoloff, Ph.D.

Brief Description: The TRICARE health care program evaluation use responses to the Survey of DoD Health Care Beneficiaries to evaluate the changes in access to and quality of care which have taken place since the inception of TRICARE. Since many of the questions in the DoD survey are based upon CAHPS items, this analysis will compare responses of those from the DoD population receiving their health care from TRICARE with individuals represented in the NCBD database on common CAHPS items. The comparison will be limited to adult respondents.

Timeframe: Access to CAHPS 2.0 data approved through February 2001.

Current Status:

Results of this evaluation have been approved by the Under Secretary of Defense for Health Affairs and have been forwarded to the U.S. Congress in a report entitled, "Evaluation of the TRICARE Program: FY2000 Report to Congress." The report is available to the general public.

Contact Information:

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Comparison of CAHPS® Adult Survey Results with CAHPS® Child Survey Results

Principal Researcher: Judy Sangl, PhD

Brief Description: This project seeks to determine if there are any differences in member satisfaction ratings between adults for their own care and adults' opinion of their experiences with their children's care: (1) among different plans, and (2) among different racial/cultural groups, and (3) among different types of insurance (commercial versus Medicaid).

Timeframe: Access to CAHPS 2.0 data approved through March 2001.

Current Status: Preliminary findings were presented to the NCQA Committee on Performance Measurement in May 2000. Additional analyses are being conducted, and a manuscript will be submitted to a journal for publication by March 2001.

Contact Information:

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Rockville, MD 20852
(301) 594-1702
(301) 594-2155
jsangl@ahrq.gov

Implications of (Mis-)Using the CAHPS® Star Charts for Comparing Individual Health Plans

Principal Researcher: Scott Scheffler, M.Ap.St.

Brief Description:

This analysis will investigate the implications of (mis-)using the CAHPS "star charts" for the purpose of comparing individual plans against each other rather than against the average of the plan means. Analyses will involve pair-wise comparisons that are controlled through a family-wise error rate. These comparisons will then be examined with how they relate to their star ratings.

Timeframe: Access to CAHPS 2.0 data approved through September 2001.

Current Status: This study is still in progress.

Contact Information:

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(919) 541-6722
sscheffler@rti.org

Case-Mix Adjustment of CAHPS® 2.0 Reporting Composites

Principal Researcher: Elizabeth R. Woods, MD, MPH

Brief Description:

This study will evaluate different case-mix models for adjusting plan level scores based on the children's version of CAHPS 2.0. We propose examining the following research issues:

a. Different models for case-mix adjustment of CAHPS plan level scores will be compared. We will assess both the degree to which member characteristics are related to CAHPS scores and the amount of inter-plan variability (relative to within plan variability) when selecting potential adjusters. Potential case-mix variables to be evaluated include age of parent, age of child, reported health status of child, sex of child, sex of parent.

b. The effects of the case-mix adjustments on plan scores will be assessed.

Timeframe: Access to CAHPS 2.0 data approved through November 2002.

Current Status: This study is still in progress.

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National Healthcare Quality Report

Thomas W. Reilly, Ph.D.
Agency for Healthcare Research and Quality

Seventh National CAHPS User Group Meeting
March 8, 2001

Serves the needs of policymakers

Overview

- Background on the National Healthcare Quality Report (NQR)
- Current NQR activities
  - How CAHPS fits in
- Future plans

Why a National Quality Report

- Healthcare Research and Quality Act of 1999 (P.L. 106-129)
- President's Advisory Commission on Consumer Protection and Quality in the Healthcare Industry

Agency Reauthorization Language

- "… The Committee expects the Agency to use a variety of measures (akin to the way the "leading economic indicators" inform us about the health of the economy) to develop this annual picture of how quality is faring."

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Example Uses

- Inform Congress, providers, and consumers about the quality of health care in the nation
- Identify areas for improvement
- Help form consensus for action
- Monitor progress over time
- Help guide resource allocations
- Provide national benchmarks

Reilly 5

comprehensive picture of how our healthcare system is performing.

Current Activities

- Conceptual framework
- Measures and data
- Research on report design
- Coordination

Reilly 6

Conceptual Framework

- Institute of Medicine (IOM) Committee formed to provide recommendations
  - 14-member committee, chaired by Drs. William Roper and Arnold Epstein
  - Expert testimony from a variety of sources
  - Identified candidate frameworks
  - Final report due Spring, 2001

Preliminary IOM Framework

- Chassis goals
  - Safety
  - Effectiveness
  - Patient-centered
  - Timeliness
  - Efficiency
  - Equity
- FACCT framework
  - Staying healthy
  - Getting better
  - Living with illness
  - Coping with changing needs

Measures for the Report

- Identify pool of candidate measures
  - Call to Federal agencies
  - IOM call to private sector
- Populate the reporting framework
- Evaluate candidate measures
- Identify gaps to help define future research agenda in quality measurement

Measures: Evaluation Criteria

- Objectively based on substantial research
- Relevant to intended audiences
  - Meaningful
  - Health importance
  - Strategic
  - Controllable
  - Timely
- Scientifically Sound
  - Clinical Evidence
  - Reproducible
  - Valid
- National data
- Amenable to subgroup analysis (e.g., State, race/ethnicity)

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Examples of Date Sources

- Population-based data collection efforts
- Establishment/provider-based data collection efforts
- Administrative/regulatory data collection efforts
- Vital statistics
- Surveillance activities

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Existing Federal Data
Private Sector Data

Sources of CAHPS Data

- National CAHPS Benchmarking Database
- Medical Expenditure Panel Survey (MEPS)
  - MEPS includes selected CAHPS questions

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- National Nursing Survey
- Cancer Registry Data

Where CAHPS Fits In

	Classic goals for health care					
IACCT dimension	Safe	Effective	Timely	Patient centered	Efficient	Equitable
Staying healthy			\	\		\
Getting better			\			\
Living with illness			\	\		\
Changing needs						

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CAHPS Measures, Timely/Staying Healthy

Measure	Data source
Percent of relevant population who report that they always get an appointment for regular or routine care as soon as they wanted	MEPS, NCHD
Percent of relevant population who report that it was not a problem to get the care they or doctor believed necessary	MEPS, NCHD
Percent of relevant population who report that it was not a problem to get a referral to a specialist they needed to see	MEPS, NCHD
Percent of relevant population who report that they never wait in doctor's office or clinic more than 15 minutes past appointment time	NCHD
Percent of relevant population who report that delays in health care are not a problem while waiting for approval from health plan	NCHD

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Research on Report Design

- Purpose
  - Identify the needs of potential audiences and design products to meet those needs
- Products
  - Written report(s)
  - Web-based reporting system
- Current activities
  - Conduct iterative consumer research
  - Inventory products of similar reporting projects

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Coordination

- Within the public sector
- With related private sector efforts
- International collaboration

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Milestones for the First Report

- Final framework - May 2001
- Final measure set - October 2001
- Final report design - January 2002
- Final results generated - September 2002
- Final draft of report - February 2003
- Final clearance of report - August 2003
- Report sent to Congress - August 2003

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Apply lenses to other providers

Example Developmental Activities

- Evaluation for on-going improvement
- Research on quality measurement
  - Develop measures to fill gaps in conceptual framework
  - Assess psychometric properties of existing measures
  - Develop composite measures
- Expand data sources
  - Enhance existing data sources
  - Identify additional data sources
- Develop reporting products

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Summary

- The NQR will provide information to policy makers to monitor the Nation's progress toward improved health care quality
- We are currently in the design phase of the NQR, leading to the first report in FY2003
- CAHPS will play an important role
- Underlying approach: evolutionary process

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International Comparisons

QHIP

- Monday 5-6p in Zeus A

The "Children with Special Health Care Needs (CSHCN) Module"

Christina Bethell, PhD
Joe Thompson, MD

Presented at the
7th Annual National CAHPS
User Group Meeting

March 8, 2001

The "Children with Special Health Care Needs (CSHCN) Module"

- PURPOSE:
  - **To generate & report relevant, actionable information about the quality of care for children with on-going health conditions to consumers & other audiences.**
- DESCRIPTION:
  - **The CSHCN Module is a set of methods & tools designed to identify CSHCN & to assess essential aspects of care for this group**

The CSHCN Module

Five Components:

1. **A core patient experience of care survey, the CAHPS 2.0 Child Survey**
2. **The CSHCN screener, a 5-item tool to identify children w/ chronic or special health care needs**
3. **The CSHCN question supplement addressing topics especially relevant to CSHCN & their families**
4. **A dx-code based administrative data algorithm for use in an enriched sampling strategy (optional)**
5. **Guidelines for scoring & presenting the CSHCN-specific measures collected by CSHCN Module**

CSHCN Module

- 5 item CSHCN Screener using non-categorical criteria to identify CSHCN
- CSHCN Question Supplement (31 items) assessing concepts of care essential for CSHCN regardless of clinical nature or severity
- Enriched sampling strategy minimizing sample size necessary to achieve statistically adequate cohort of CSHCN for performance comparison
- Sampling design preserving standard CAHPS sample while also making it possible to stratify results for CSHCN and non-CSHCN groups

Who are "Children with Special Health Care Needs?"

"Children with special health care needs . . . a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."

— Maternal and Child Health Bureau, July 1998

Motivation

- Quality for CSHCN is often inadequate (about 40-60% of optimal on clinical indicators, 50-80% on experience of care)
- Increasing mandates to focus on quality of care for CSHCN clients in Medicaid and S-CHIP
- Need for a common, standardized approach to identify and assess quality for CSHCN in health plans and other settings.

Motivation

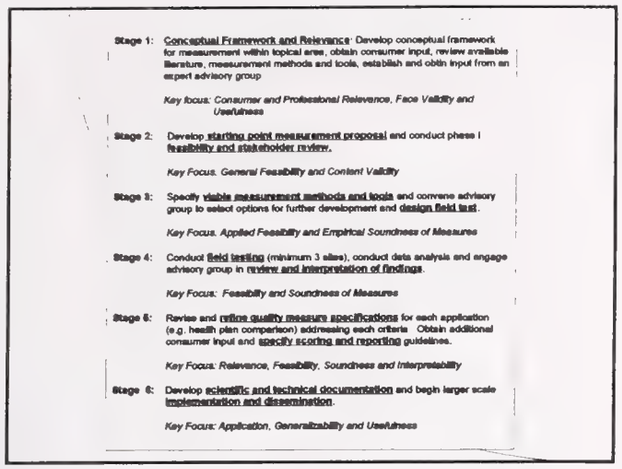
- Health care needs of CSHCN differ in type, scope, frequency, duration & complexity
- Majority of child health care dollars (80-90%) spent for CSHCN
- Assessment of care for CSHCN provides more sensitive indicators of quality

Major Challenges

- The epidemiology of children w/ chronic conditions makes condition by condition assessments impractical for performance comparison
- Single condition monitoring provides inadequate view of overall quality of care
- Condition checklists and/or administrative dx data have limited utility for prevalence or performance measurement (although can be useful components)
- Sample size & capacity to preserve CAHPS trending data important feasibility considerations

Development Background

- Began March, 1998.
- Guided by CAHMI Six-Stage Measurement Development Process
  - Conceptual framework and relevance
  - Starting point proposal review
  - Methods specification and study design
  - Field testing
  - Revision and refinement
  - Document and disseminate



Stage 1: Conceptual Framework and Relevance: Develop conceptual framework for measurement within topical area, obtain consumer input, review available literature, measurement methods and tools, establish and obtn input from an expert advisory group

Key focus: Consumer and Professional Relevance, Face Validity and Usefulness

Stage 2: Develop starting point measurement proposal and conduct phase I feasibility and stakeholder review.

Key Focus. General Feasibility and Content Validity

Stage 3: Specify viable measurement methods and tools and convene advisory group to select options for further development and design field test.

Key Focus. Applied Feasibility and Empirical Soundness of Measures

Stage 4: Conduct field testing (minimum 3 sites), conduct data analysis and engage advisory group in review and interpretation of findings.

Key Focus: Feasibility and Soundness of Measures

Stage 5: Revise and refine quality measure specifications for each application (e.g. health plan comparison) addressing each criteria Obtain additional consumer input and specify scoring and reporting guidelines.

Key Focus: Relevance, Feasibility, Soundness and Interpretability

Stage 6: Develop scientific and technical documentation and begin larger scale implementation and dissemination.

Key Focus: Application, Generalizability and Usefulness

Development Background

- 6 in-person national meetings of CAHMI Living with Illness Task Force involving consumers, providers, researchers, policymakers, etc.
- 25 to 30 Living with Illness Task Force Advisory Group conference calls over course of work
- Innumerable e-mails & "real time" review sessions among Task Force members & advisors
- Field trials collecting over 26,000 cases of survey data

Players

- CAHPS Team
- NCQA
- Family/consumer organizations -- Family Voices
- Provider groups -- AAP, NACHRI, AAFP
- Federal agencies - HCFA, HRSA, MCHB, AHRQ
- State agencies -- numerous Medicaid/S-CHIP representatives
- Academic experts -- Newacheck, Stein, Perrin

Context & Criteria

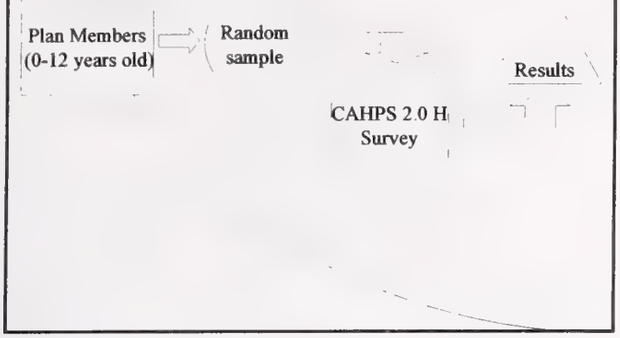
- CAHMI Measure Selection & Development Criteria:
  - Meaningful
    - Consumer relevance
    - Discriminating and actionable
    - Non-redundant w/ current measurement
  - Feasible
    - Short, survey-based, dual mode(mail & telephone)
    - Compatible with CAHPS tools - wording, format, reading level, translation, scoring
    - Minimize burden
  - Sound
    - Reliable - psychometric reliability, cognitive ease
    - Valid - face, content, concurrent, criterion

Major Questions

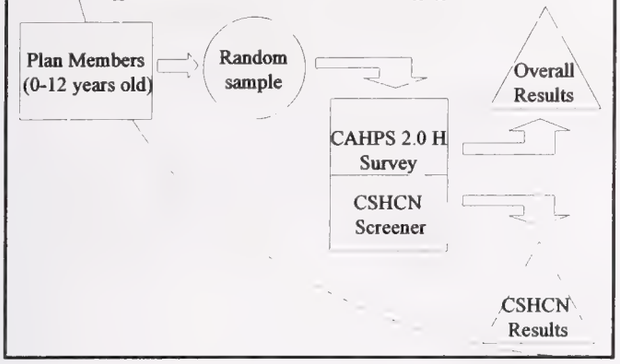
- **How do we identify these Children with Special Healthcare Needs (Screener)?**
- **What do we ask of these CSHCN (Supplemental Questions)?**
- **How can we efficiently deploy a survey for CSHCN (Feasibility)?**

How do we identify these Children with Special Healthcare Needs (Screener)?

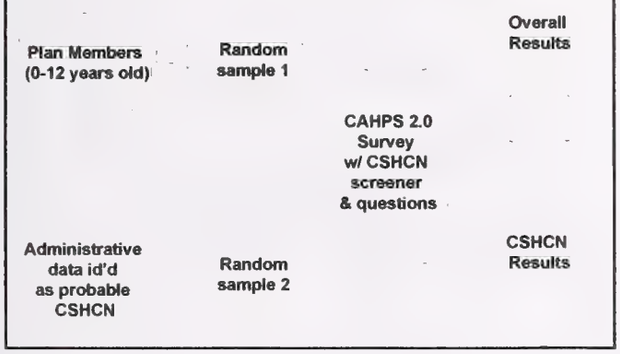
Existing Child Survey



CSHCN Child Survey Population-Based Approach



Enriched Sampling Strategy



Testing

- **PHASE I:** 18 Focus grps w/ parents (8 CSHCN-specific)
  Cognitive interviews w/ instruments
- **PHASE II:** Field trials in 4 health plans (mail & phone)
  2 commercial; 1 Medicaid HMOs
  1 mixed model MCO 1,995 surveys collected
- **PHASE III:** Validation of CSHCN screening tool (phone only)
  1 mixed model MCO; 2 national samples
  12,471 cases collected
- **PHASE IV:** WA State Medicaid Pilot Study (mail & phone)
  9 Medicaid HMOs; 1 FFS/SSI sample
  12,143 surveys collected

Testing

• CAHPS w/ CSHCN screener & questions	14,138 cases collected
• CSHCN screener (w/ QuICCC-R and/or other validation data)	12,471 cases collected
Total	26,609 cases collected

PHASE II adjusted response rate: 52.7%
(mean across 4 sites)

PHASE IV adjusted response rate: 57.7%
(mean across 9 sites)

CSHCN Screening Tool

- Original goal: **Identify CSHCN for purposes of quality assessment & reporting**
- **For broad-based, standardized use in quality assessment we needed:**
  - **Short tool**
  - **Tool that would minimize "false positives" while still identifying the broad range of children having chronic or special health needs**
  - **Tool that could be used by mail or telephone**
  - **Tool reflecting a consensus definition of CSHCN**

History of the CSHCN Screener

- Questionnaire for Identifying Children with Chronic Conditions (QuICCC)
  - 36 items / 117 components, in-person questionnaire (Ruth Stein, et al., 1997)
- QuICCC-Revised
  - 16 items / 41components (telephone or in-person)
- CSHCN Screening Tool
  - 5 items / 14 component survey version (mail or phone)

CSHCN Screening Tool

- Uses non-condition specific criteria to identify CSHCN
- Why?
  - Urgent need for comparative information
  - Technical limitations of sample size for specific conditions (e.g. juvenile diabetes)
  - Minimizes potential for condition-specific adverse selection in plan membership
  - Quality information useful to broadest number of consumers

CSHCN Screening Tool

Five current consequences "triggers"

- Limited or prevented in ability to function
- Prescription medication need/use
- Specialized therapies (OT, PT, Speech)
- Medical care, mental health or educational services need/use above what is routine for age
- Counseling or treatment for on-going emotional, behavioral or developmental problem

---

1) Due to medical, behavioral or other health condition

AND

2) Condition has lasted or is expected to last for at least 12 months

CSHCN Screening Tool

- PHASE I field trials led to final version of tool
  - original CAHPS chronic condition items eliminated from consideration based on results; CAHPS team retires items in favor of the CSHCN tool
  - checklist format eliminated
  - 2 part vs. one part follow up format preferred; ensures consistent mail/phone administration
- Final version of tool fielded in PHASE III & IV studies
  - comparison w/ QuICCC-R in two samples
  - comparison w/ 3M-CRG system in one sample
  - nationally representative samples / SLAITS pre-tests
  - administered as part of CAHPS survey in 10 samples (English and Spanish)

Key Findings
Proportion of CSHCN identified

	CSHCN Screener		QuICCC-R
SLAITS Pre-Test	16.6%		24.2%
CAHMI Trials			
Population	19-21%	25%	
SSI	95%		n/a
CRG level 3 or 4	98%		98%

Key Findings
Agreement with Other Methods

- Agreement with QuICCC-R
  - Agree 9 out of 10 times
  - PPV Screener - 93%
  - NPV Screener - 89%
  - Discrepant group different in specific number and content of items qualifying on on the QuICCC-R and in probability that parents name a condition or child has a chronic diagnostic code or indication of condition in medical records
- Agreement with 3M-CRG classification
  - Agree 9 out of ten times
  - PPV Screener - 67%
  - NPV Screener - 93%

Key Findings

	CSHCN	Non-CSHCN
Parent-reported rating of child's health now:		
% "Excellent / Very good"	62%	87%
% "Fair / Poor	10%	2%
Child had 1 or more acute conditions during last 12 months	63%	55%

WA State Medicaid Pilot Study, CAHMI 2000

Key Findings

	CSHCN	Non-CSHCN
Q53: Needed medical equipment/ past 6 mos.	13%	3%
Q56: Needed special therapy / past 6 mos.	19%	4%
Q59: Tx or counseling for emotional or other issue / past 6 mos.	33%	4%
Q76: Needed new prescription medicine or refill / past 6 mos.	81%	45%

WA State Medicaid Pilot Study, CAHMI 2000

Key Findings

- **WA State Medicaid Pilot**
  - **In random child population sample:**
    - **20.7% CSHCN overall, (9 plans)**
    - **Range 17% — 25% CSHCN**
  - **In random child population sample, % qualifying on:**

	OVERALL	*RANGE*
Q1: Rx meds:	14.4%	11.6 — 16.5%
Q2: Service use:	9.7%	6.8 — 13.4%
Q3: Func. limits:	6.4%	4.4 — 8.4%
Q4: Therapies:	3.4%	2.5 — 4.6%
Q5: Mental hlth:	9.7%	6.3 — 12.7%

Key Findings

Differences exist in quality for CSHCN and non-CSHCN groups in same health plan:

CSHCN vs. Non-CSHCN Results

Domain	Within plan differences*
CAHPS: How well drs. communicate	2 out of 9 plans
CAHPS: Getting care quickly	1 out of 9 plans
CAHPS: Getting needed care	9 out of 9 plans
CAHPS: Courteous/helpful staff	1 out of 9 plans
CAHPS: Customer services	5 out of 9 plans

WA State Medicaid Pilot Study, CAHMI 2000 *p≤.01

What do we ask of these CSHCN (Supplemental Questions)?

CSHCN Question Supplement

Comprised of 31 items (includes filter questions), the CSHCN Question Supplement adds 4 new domains for assessment:

- Getting Prescription Medicines
- Getting Specialized Services
- Family-Centered Care
  - Personal dr/nurse who knows child
  - Getting needed information about child's health
  - Shared decision making
- Coordination of Care & Services

CSHCN Question Supplement

- Consumer Relevance:
  - Focus groups with families
  - Family Voices input and national survey
  - Build off of the emerging CAHPS CSHCN survey
  - Where needed, adapted existing item/scales or developed new ones to reflect aspects of care families identified as important (e.g. Shared Decision Making, Prescription Medicines, Specialized Services, Coor. of Care)

CSHCN Question Supplement

- Scientific Strength:
  - Literature review to identify essential aspects of care for successful tx, mgmt & support of children with chronic conditions
  - On-going input from Advisory Panel experts to establish & confirm face & content validity
  - Selection of concepts/areas where possible w/ demonstrated empirical links to child health outcomes (e.g. Shared decision making; pt educ)
  - Discarding of concepts that did NOT satisfy the above (e.g. Written care plan; "partnership" w/ provider; provider supportive of family's caregiving; generic symptom mgmt, etc.)

CSHCN Question Supplement

- Discriminating:

  Significant variation in quality among health plans exists for CSHCN: *F value ranges (9 sites)*
  - Standard CAHPS composites 12.6 – 4.4 (p's ≤ .000)
  - CSHCN measures 7.3 – 3.6 (p's ≤ .001)

- Opportunity for improvement:
  - Care for CSHCN often lower, but not uniformly so
  - In a few plans, CSHCN grp outscored Non-CSHCN grp on some measures
  - Taken together, demographic & health status variables "explain" less than 4% of variation in individual scores

CSHCN Question Supplement

- Need for improvement exists:
  - CAHPS: Getting Needed Care
    - Sig. lower btw. CSHCN & Non-CSHCN: 9 out of 9 plans
  - CAHPS: Customer Service
    - Sig. lower btw. CSHCN & Non-CSHCN: 5 out of 9 plans
  - CSHCN: Getting Prescription Medicines
    - Sig. lower btw CSHCN & Non-CSHCN: 9 out of 9 plans
  - CSHCN: Getting Specialized Services
    - Sig. & wide variation btw. plans for CSHCN
  - CSHCN: Coordination of Care
    - Overall performance very low
    - Sig. & wide variation btw. plans for CSHCN

CSHCN Question Supplement

- Provides "new", non-redundant information

Correlation (Pearson r): CAHPS composites & CSHCN measures

	CAHPS: Dr Communication	CAHPS: Getting Care Quickly	CAHPS: Getting Needed Care
CSHCN: RX Meds	.17**	.17**	.27**
CSHCN: Specialized Services	.31**	.26**	.46**
CSHCN: Family Centered Care Components	.58-.65**	.38-.50**	.28-.38**
CSHCN: Coor. of Care & Services	.46**	.35*	.35**

WA State Medicaid Pilot Study, CAHMI 2000 ** $p \geq .000$

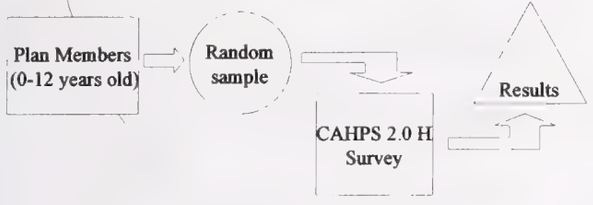
How can we efficiently deploy a survey for CSHCN (Feasibility)?

Enriched Sampling Strategy

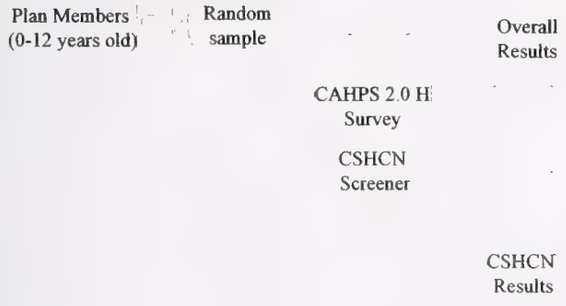
Purpose:

- Relatively low prevalence of CSHCN in general population raises sample size issues for survey-based identification methods
- For many applications, it may be desirable to minimize the starting sample size needed to achieve a targeted number of CSHCN by increasing number of children likely to be CSHCN
- The CSHCN Module includes a pre-specified dx-code list for use with administrative records to "prescreen" for a cohort of children having a higher probability than average of meeting the survey-based screening tool

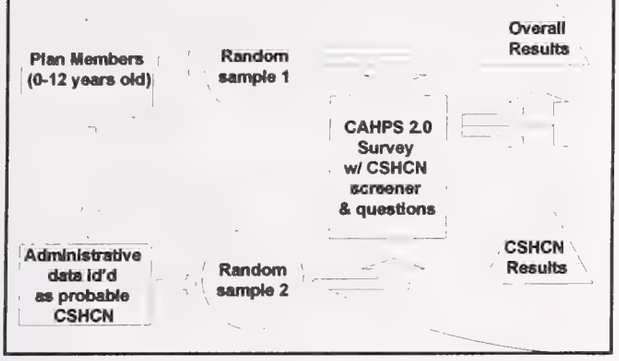
Existing Child Survey



CSHCN Child Survey Population-Based Approach



Enriched Sampling Strategy


Plan Members (0-12 years old)
Random sample 1
Overall Results
CAHPS 2.0 Survey w/ CSHCN screener & questions
Administrative data id'd as probable CSHCN
Random sample 2
CSHCN Results

3 Options for Over-sampling

- Most costly children (e.g. hospitalization, special services, etc.)
- Children who have the highest utilization rates (outpatient, inpatient, special therapies)
- Previously diagnosed conditions (list of ICD-9 codes with "high-probability)

Receiver Operator Curves

- INSERT GRAPHIC

Enriched Sampling Strategy

- 8-11% of survey eligible children across the 9 plans met prescreen criteria (1 or more dx codes from list)
- Most common diagnoses among the group meeting prescreen criteria:

	MCO	SSI
• ASTHMA	31%	15%
• ADHD/ADD	12%	13%
• CONGENITAL ANOMALIES	11%	15%
• HEARING LOSS	10%	9%
• MENTAL HEALTH (Depression, neuroses, eating disorders, substance abuse)	9.8%	14%
• DEVELOPMENTAL DELAY	8%	17%

WA State Medicaid Pilot Study, CAHMI 2000

Enriched Sampling Strategy

- Consistent CSHCN "catch" across plans
  - Overall, 52% of the children in the dx code "prescreen" group met the survey-based CSHCN screening tool (range across 9 plans: 51% to 58%)
- Similar screener results across plans:

	OVERALL CATCH (%)
Q1: Rx meds:	27.3 – 30.8
Q2: Service use:	19.4 – 22.6
Q3: Func. limits:	11.7 – 13.6
Q4: Therapies:	5.0 – 7.5
Q5: Mental hlth:	15.5 – 18.2

Scoring & Presentation

Options and Issues:

- Mutually exclusive vs. non-mutually exclusive groups for scoring/presentation
- Scoring of the benefit structure related items (RX medicines and specialized services
- Absolute vs. relative scoring
- Incorporating prescreen group cases that not meet CSHCN screener

Benefit structure and its Impact on Survey Design

- Insert Graphic on Benefits

Supplemental Question (exp.)

- Use Prescription drugs

Interpretation dependent upon benefit structure

- Insert table

Other Issues

- Mode of administration
  - In WA State Pilot study, CSHCN did NOT vary significantly by mode (mail or phone)
- "Multi" child responders effect on CSHCN estimates
  - In WA State Pilot Study, about 12% may have responded to survey for more than 1 child
- Adolescent self-report vs. parent reporting
- Other applications of the CSHCN screener
- Cultural competency

Spanish vs. English

In WA State Medicaid Pilot Study:

- 10% of surveys were collected in Spanish
- More of the Spanish than English language surveys were collected by telephone (English 19%; Spanish 36%)
- 46% of respondents answering "Yes, my child is Hispanic" responded to survey in Spanish
- Nearly 100% of those who responded in Spanish described their child as being Hispanic

Spanish vs. English

In the WA State Pilot Study, children described as "Hispanic" tended to be id'd as CSHCN at a lower rate than non-Hispanics

- Hispanic child, survey collected in English
  - 18% met CSHCN screener (vs. 21% non-Hispanic)
  - SLAITS pretest found similar difference (14% CSHCN Hispanic vs. 16% CSHCN non-Hispanic)
- Hispanic child, survey collected in Spanish
  - 10% met CSHCN screener

Spanish vs. English

- Age distribution in Spanish language group may explain some of the CSHCN rate difference
  - Mean age: 6 yrs / Spanish grp vs. 8 yrs / English grp
- Reading level of screener does not appear to be implicated
  - Mode of administration did NOT significantly effect CSHCN screening rates in Spanish
- A mix of cultural & translation factors may be involved
  - A child described as being Hispanic was more likely to meet CSHCN criteria if the survey was collected in English

Spanish vs. English

Despite lower CSHCN rates for group responding in Spanish:

- 20% of parents in Spanish grp rated their "child's health now" as 'fair' compared to 6% in English grp
- Spanish grp reported twice the rate of NO dr/clinic visits during past 6 mos. (35% / Spanish vs. 18% / English)
- Level of ER utilization, however, was the same for children in both the Spanish & English language groups

The CSHCN Module

Five Components:

1. A core patient experience of care survey, the CAHPS 2.0 Child Survey.
2. *The CSHCN screener*
3. *The CSHCN Question Supplement*
4. *Enriched sampling strategy*
5. *Scoring & presentation guidelines*

Methods Overview

- 5 item CSHCN Screener using non-categorical criteria to identify CSHCN
- CSHCN Question Supplement (31 items) assessing concepts of care essential for CSHCN regardless of clinical nature or severity
- Enriched sampling strategy minimizing sample size necessary to achieve statistically adequate cohort of CSHCN for performance comparison
- Sampling design preserving standard CAHPS sample while also making it possible to stratify results for CSHCN and non-CSHCN groups

Scoring & Presentation

- The CSHCN Module yields 2 sets of consumer reporting measures:
  - For regular CAHPS random population sample
    - 5 CAHPS composites
    - 3 CAHPS rating scales
  - For CSHCN group ONLY:
    - 5 CAHPS composites
    - 3 CAHSP rating scales
    - 4 CSHCN-specific composites

Scoring & Presentation

CSHCN-specific composites:

- Getting Prescription Medicines
- Getting Specialized Services
- Family-Centered Care
  - Personal dr/nurse who knows child
  - Getting needed information about child's health
  - Shared decision making
- Coordination of Care & Services

Status of CSHCN Module

- Version of the CSHCN Module *(HEDIS/CAHPS 2.5H Child Survey)* accepted for inclusion in HEDIS 2002. Public review in process.
- Technical documentation for national CAHPS users group currently underway
- 3.0 version of CSHCN Module in final stages of testing and confirmation
- CSHCN screening tool being used nationally in MEPS; SLAITS and various State settings

More information

- www.facct.org/cahmi.html
- www.ncqa.org -- public review documents
- childs@facct.org

Evaluating Quality of Care Information in the *Medicare & You* 2000 Handbook

Lauren McCormack PhD, Wayne Anderson MDiv,
Sarah Daugherty MPH, May Kuo PhD,
Kevin Ross MSPH, Steven Garfinkel PhD

CAHPS User Group Meeting

March 8, 2001

Presented by Lauren McCormack

RTI

National Medicare Education Program (NMEP)

- Multifaceted educational campaign led by the Health Care Financing Administration
- Goals of the NMEP are to:
  - Increase beneficiary **access** to information
  - Raise beneficiary **awareness** of new plan options and information resources
  - Help beneficiaries **understand** the choices available to them
  - Help beneficiaries **use** the information to make informed choices

2

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Contents of the *Medicare & You* 2000 Handbook

- overview of Medicare program and basic benefits
- description of different Medicare plan choices
- information on how to get assistance
- Medicare beneficiary rights and protections
- quality of care information (1 CAHPS and 1 HEDIS measure) for local area managed care plans

3

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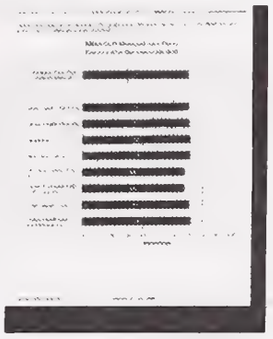
Example of CAHPS Bar Chart



4

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Research Questions

- What are Medicare beneficiaries' impressions of the *Medicare & You* 2000 handbook?
- Was exposure to quality information associated with certain attitudes about Medicare and health insurance?
- What was the effect of quality information on beneficiary knowledge and the likelihood of reading the handbook, controlling for other factors?

5

RTI

Study Design

	1999		2000	
	July	Oct	Feb	May
Control group survey	———			
		X		
Treatment group survey		———		
Focus groups				|-|

X= National mailing of the *Medicare & You* 2000

6

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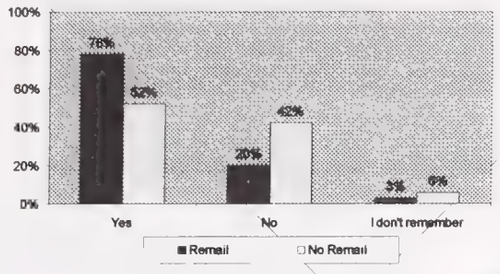
Have You Recently Seen a Copy of the *Medicare & You* 2000 Handbook?*



* Significant at the .05 level

7

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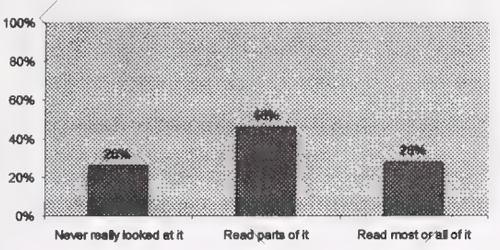
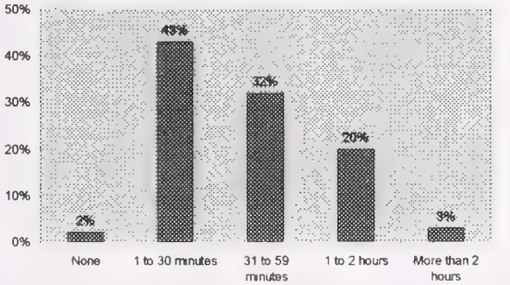
How Much of the Handbook Did You Read?



8

RTI

How Much Time Did You Spend Looking at the Handbook?



9

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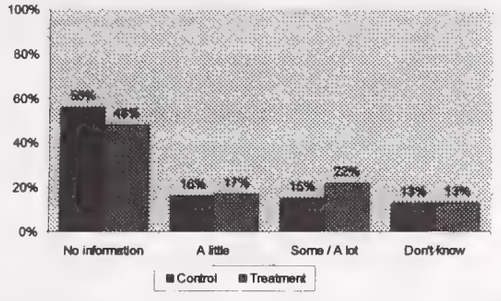
Quality Information Received on Doctor Communication*

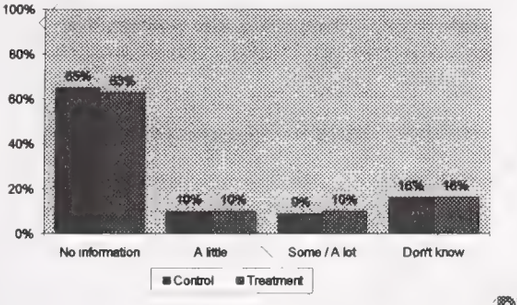


* Significant at the .05 level

10

RTI

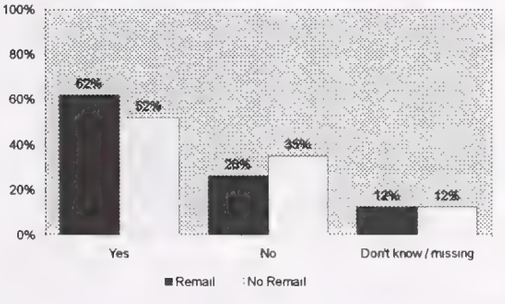
Quality Information Received on Cancer Testing



11

RTI

Did you Learn Anything New from the Handbook?+*



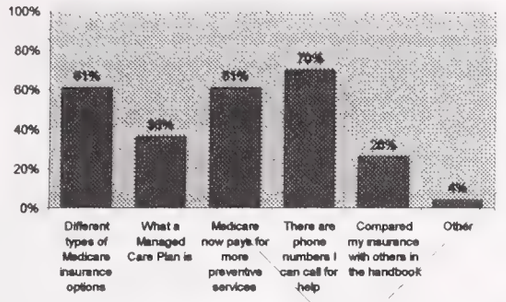
+ Treatment group only

* Significant at .05 level

12

RTI

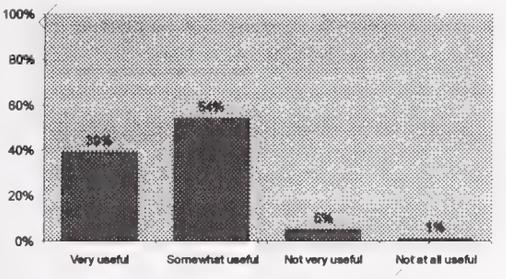
What Did You Learn from the Handbook?+



13 + Treatment group only

RTI

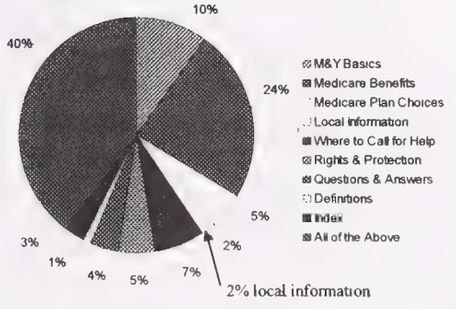
Overall, How Useful was the Information in the Handbook?+



14 + Treatment group only

RTI

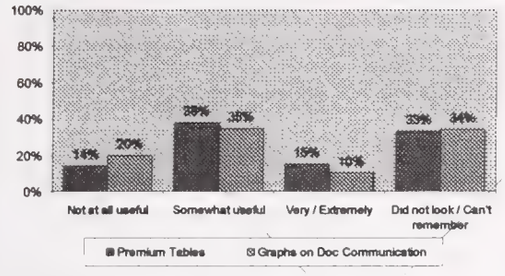
Most Useful Section in M&Y 2000 Handbook+



15 + Treatment group only

RTI

How Helpful were Quality Graphs and Premium Tables?+



+Treatment group only

16

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Exposure to CAHPS Measure (Slide 1)

Receiving a lot/some information on doctor communication was associated with:

- having (pre-Medicare) managed care experience
- having a positive attitude about managed care
- satisfaction with information that is available about the Medicare program
- confidence in current health plan choice
- finding it easier to choose a plan

17

RTI

Exposure to CAHPS Measure (Slide 2)

Receiving a lot/some information on doctor communication was *not* associated with:

- perception of the level of importance of the Medicare plan decision
- believing that the plan you choose affects the quality of care you get
- satisfaction with current health plan
- changing health plans (or thinking about changing)
- using the Medicare web site or counseling service

18

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Exposure to CAHPS Measure (Slide 3)

Controlling for other factors, exposure to CAHPS measure:

- resulted in having a higher knowledge score on a 22-item knowledge index
- the likelihood of reading the Handbook
- having at least enough information about Medicare

19

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Conclusions and Policy Implications about CAHPS Information

- Mixed reactions by those who noticed it
- Educating beneficiaries about Medicare plan options, but not influencing decision making
- Need to educate beneficiaries about managed care to increase use of CAHPS information

20

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Education Level and Associated Understanding and Usability of Medicare Health Plan Information

E. Jaël, M.P.H.
S. Bernard, Ph.D., R.N.
L. Harris-Kojetin, Ph.D.
R. Bender, Ph.D.
E. Hoy,M.H.A.
B. Koetse

Funded By
AHRQ
&
HCFA

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Methods

- Two Rounds of Focus Groups
- Three Rounds of Cognitive Testing
- Two Rounds of Usability Testing
- Mix in education, age, and race

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Goals

- What do beneficiaries know about their health plan choices?
- What is the best way to present health plan choices?
- What context information do beneficiaries need?
- What is the best way to present the data?

Ensure Comprehension of Basic Information

- Rules and options are difficult to understand
- Providing information about health plan options in a table increases comprehension

Features of the Different Medicare Health Plan Choices

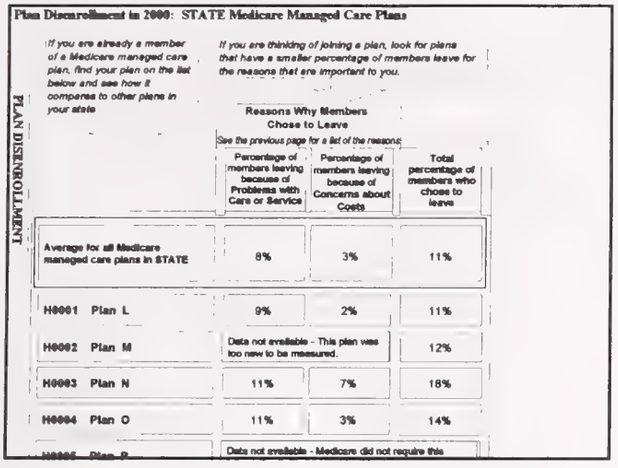
These pages show the basic features of each of the Medicare plan choices that may be important to you as you choose a plan. You will want to look at additional information, but this can give you an overview of the differences among the Medicare health plans

New terms are in red. See page 10 for description of each term.

Features Look at the features below and read across the rows to compare the plans.	Original Medicare Plan	Medicare Managed Care Plan	Private Fee-For-Service Plan This type of health plan is new.
Can I choose the doctors and hospitals I want?	• You can choose your own doctors and hospitals. Almost all doctors and hospitals in the United States accept Medicare. • You can see a specialist without getting approval from your **primary care provider**	• You usually must see doctors and hospitals from the plan's network. • You usually must get a **referral** from your **primary care provider** to see a specialist.	• You can choose your own doctors and hospitals in the United States that accept the Private Fee-for-Service Plan. • You can see a specialist without getting approval from your primary care provider.
What will my out-of-pocket costs be?	• You will have to pay **deductibles** and **co-insurance** • Doctors who do not accept Medicare payment amount can charge you up to 15% above the Medicare's payment amount.	• You may have to pay an additional **premium** • You usually must pay a small **co-payment** for services.	• You may pay an additional **premium**, **deductible**, and **co-insurance** amounts. • The plan may allow doctors to charge you 15% more than the plan's payment amount.
Do I need to buy Medigap policy?	You may need to get a Medigap policy to help pay for some of the costs that the Original Medicare Plan doesn't cover	You do not need a Medigap policy if you join this plan. It is illegal for someone to sell you a Medigap plan if you have this plan.	You do not need a Medigap policy if you join this plan. It is illegal for someone to sell you a Medigap plan if you have this plan.

Define Quality

- Explain why quality care is important
- Specific behaviors are easier to comprehend
- Provide as much differentiation in the data as possible.



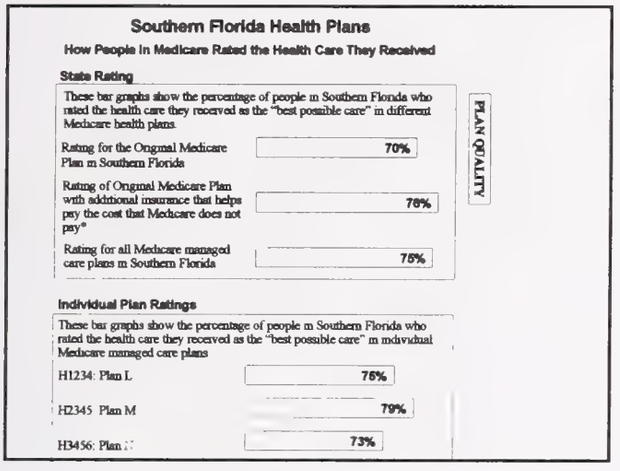
Plan Disenrollment in 2000: STATE Medicare Managed Care Plans

If you are already a member of a Medicare managed care plan, find your plan on the list below and see how it compares to other plans in your state

If you are thinking of joining a plan, look for plans that have a smaller percentage of members leave for the reasons that are important to you.

PLAN DISENROLLMENT

	Reasons Why Members Chose to Leave (See the previous page for a list of the reasons)		
	Percentage of members leaving because of Problems with Care or Service	Percentage of members leaving because of Concerns about Costs	Total percentage of members who chose to leave
Average for all Medicare managed care plans in STATE	8%	3%	11%
H0001 Plan L	9%	2%	11%
H0002 Plan M	Data not available - This plan was too new to be measured.		12%
H0003 Plan N	11%	7%	18%
H0004 Plan O	11%	3%	14%
H0005 Plan P	Data not available - Medicare did not require this		



Southern Florida Health Plans

How People in Medicare Rated the Health Care They Received

PLAN QUALITY

State Rating

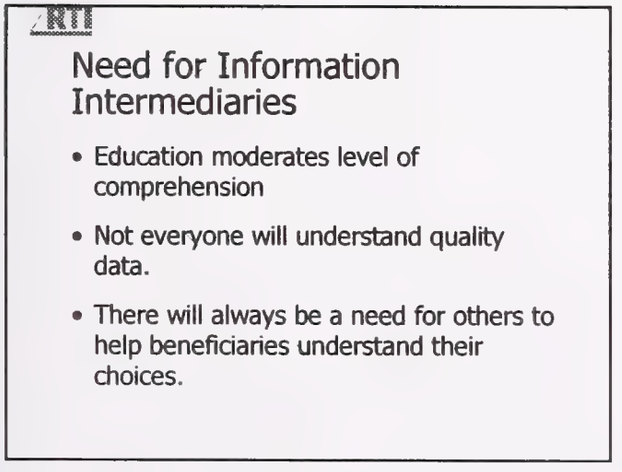
These bar graphs show the percentage of people in Southern Florida who rated the health care they received as the "best possible care" in different Medicare health plans.

Rating for the Original Medicare Plan in Southern Florida	70%
Rating of Original Medicare Plan with additional insurance that helps pay the cost that Medicare does not pay*	78%
Rating for all Medicare managed care plans in Southern Florida	75%

Individual Plan Ratings

These bar graphs show the percentage of people in Southern Florida who rated the health care they received as the "best possible care" in individual Medicare managed care plans

H1234: Plan L	76%
H2345: Plan M	79%
H3456: Plan ...	73%



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Need for Information Intermediaries

- Education moderates level of comprehension
- Not everyone will understand quality data.
- There will always be a need for others to help beneficiaries understand their choices.

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Comments on Comprehension

"Performance measures…are these complaints that have been made? What do they mean by performance measures? What does the term Medicare mean?"

RTI

Comments on Comprehension

"Spell it out for me. What's included in the quality information and how is it measured?"

Designing Useful Medicare Plan Choice Print Materials

Lauren Harris-Kojetin, PhD
Lauren McCormack, PhD
Elizabeth Jaël, MPH
Research Triangle Institute

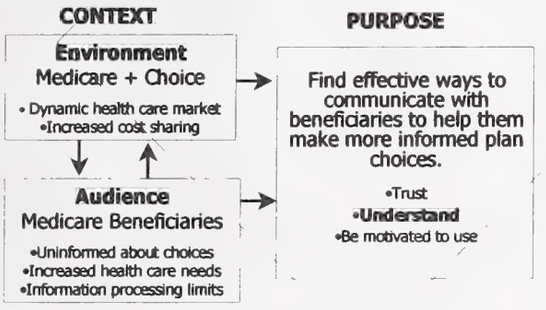
Steven Garfinkel, PhD
American Institutes for Research

CAHPS User Group Meeting • Las Vegas, Nevada
March 8, 2001

lauren@rti.org

RTI

Context & Purpose of Research



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Populations, Methods, Documents

- 3 projects for HCFA, 1 project for AARP
- Medicare beneficiaries
  - diverse geography, race, education
- 309 beneficiary participants
  - 13 focus groups and 205 in-depth interviews
- 5 sets of print documents
  - Medicare, health plans, comparative data, comparison tools

RTI

Lesson #1: Make the plan choice process cognitively manageable

- Break down complex task into a series of smaller, connected steps

Illustration #1

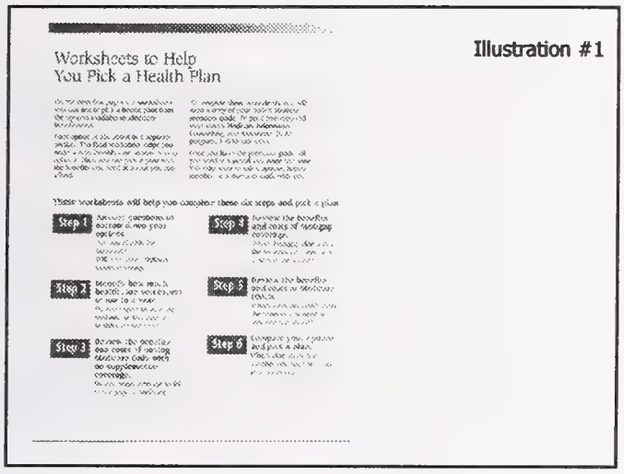
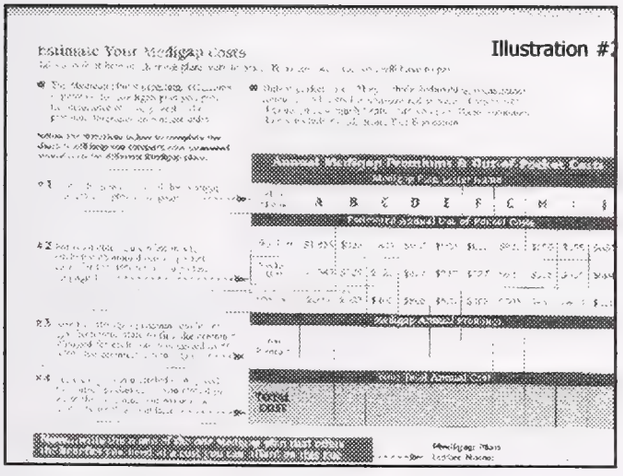


Illustration #2



RTI

Lesson #2: "Semi-structure" the plan choice

- Give beneficiaries flexible tools that accommodate different decision making styles

Illustration #3

Before Testing

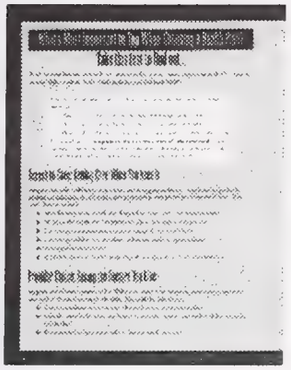
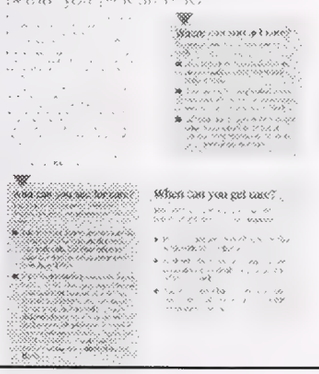


Illustration #4

After Testing



RTI

Lesson #3: Help beneficiaries learn to use numbers

- Explain whether a higher number or a lower number is better and why
- Show how to use a chart

Illustration #5

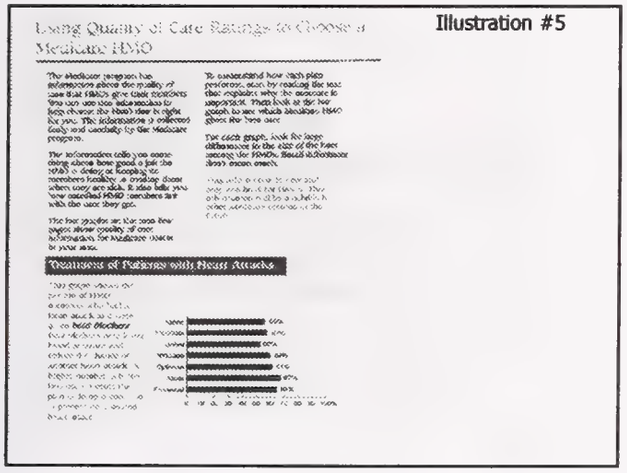


Illustration #6

Plan Disenrollment in 2000: California Medicare Managed Care Plans

If you are already a member of a Medicare managed care plan, find your plan on the list below and see how it compares to other plans in your state

If you are thinking of joining a plan, look for plans that have a smaller percentage of members leave for the reasons that are important to you.

Reasons Why Members Chose to Leave

See the previous page for a list of the reasons

	Problems with Care or Service	Concerns about Costs	Total percentage of members who chose to leave
Average for all Medicare managed care plans in California	8%	3%	11%
H0001: Plan L	9%	2%	11%
H0002: Plan M	Data not available - This plan was too new to be measured		12%
H0003: Plan N	11%	7%	18%
H0004: Plan O	11%	3%	14%

RTI

Participant Quote

"Medicare is getting more and more complicated and us senior citizens are getting less and less capable of making good decisions. It's almost as if they are muddying the waters so we can't pick out the best thing for us. And as we get older and less able, other people are going to have to do for us"

RTI

Implications

- Some beneficiaries can use print materials on their own, but many will need assistance
- The roles of different information intermediaries is increasingly important
- Decision support strategies may vary by beneficiary situation and intermediary role
  - targeting may result in more efficient resource allocation than broadcasting

Using CAHPS-FFS for Quality Improvement: Opportunities and Challenges

Paul D. Cleary, Ph.D.

CAHPS User Group Meeting

March 8-9, 2001

Suzy?

Why Use CAHPS-FFS for QI?

- Provides data on quality of care from the patient's perspective
- Widely used to facilitate consumer comparisons
- Data may reveal opportunities to improve care delivery

Why Should the PROs Be Involved in CAHPS-QI Activities?

- Largest group of QI professionals in the United States
- Extensive history of improving quality for Medicare-FFS beneficiaries
- Have developed relationships with payers and providers in their states

Assessment of Challenges and Opportunities Facing PROs

- Questions
  - What are the PROs current activities and challenges?
  - What new challenges does CAHPS present?
- Methods
  - Literature review
  - Review of PRO web sites
  - Review of HCFA-PRO database
  - Interviews with representatives of all PROs

Current PRO Activities: Populations

- Provider-defined patient populations
- Work with organizations (e.g. hospitals)
- Emphasis on inpatient care
- Variable experience with ambulatory care

Current PRO Activities: Methods & Evaluation

- Medical records or claims data
- Focus on clinical indicators rather than "benchmark data"
- Difficult to use control groups
- Little experience with CAHPS or other patient surveys

Current Challenges Facing PROs for All Quality Improvement

- Long delay obtaining quality indicators
- Difficulty recruiting providers, particularly in the ambulatory setting
- Difficult to coordinate improvement activities with clinicians not affiliated with an organization
- Rigorous evaluation studies difficult

Distinct Features of CAHPS-FFS

- Survey data
- Spans the continuum of care
- Broad spectrum of care (e.g., access; communication)
- Geographically-defined patient populations
- Measures quality due to clinicians and delivery organizations

Challenges Using CAHPS-FFS for Quality Improvement

- CAHPS perceived as less reliable, valid, and actionable than other quality indicators
- Encouraging clinician participation
- Need to develop improvement strategies compatible with current activities

Addressing the Challenges of Using CAHPS-FFS for QI

- Perceived Utility of CAHPS
  - Improving the Usefulness of CAHPS
  - Increasing PRO Familiarity with CAHPS
- Improving Clinician Participation
- Developing Effective QI Strategies

Improving Usefulness of CAHPS

- Provide analytic support
- Developing better report formats
- Research to define appropriate reporting units and comparison groups (e.g. provider/group-level CAHPS)
- Studies linking clinic programs or processes to CAHPS scores (i.e. how to "drill-down")
- Support demonstration projects

Increasing PRO Familiarity with CAHPS

- Educational materials to PROs about CAHPS
- Workshops with PROs about CAHPS
- Training by successful PROs
- Learn of experiences of health plans
- More studies relevant to PRO applications

Improving Clinician Involvement

- Workshops, educational material and training about CAHPS for clinicians
- Create incentives for clinicians
- Use CAHPS to serve other data needs
- Conduct clinically-relevant studies

Develop Effective QI Strategies

- PROs need help evaluating usefulness of different measurement and improvement approaches
- Support collaborative efforts between PROs (and other interested groups) to develop effective methods
- Consider QI demonstration projects
- Support rigorous evaluation of new techniques
- Foster sharing of ideas and successful strategies between the PROs

Conclusions

- CAHPS now most widely available standardized quality indicator in country
- PROs ideal organizations to make use of new data
- PROs face serious challenges with "traditional" quality indicators
- Successful use of a new and different indicator will require education and support of both clinicians and PROs

The Role of Performance Measures for Improving Quality in MCOs

Dennis P. Scanlon
Charles Darby
Elizabeth Rolph
Hilary Doty

7th CAHPS User's Group Meeting
Las Vegas, NV
March 8, 2001

Potential Users and Uses of Performance Measures (PMs)

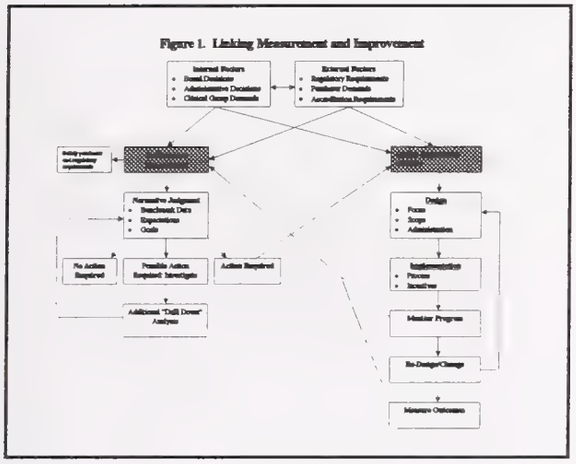
Potential User	Potential Use
Purchasers	Plan Contracting
Consumers	Plan Enrollment
Regulators	Standards Enforcement
Health Plans	**Quality Improvement**
	Sales and Marketing

Study Objectives

- Understand the organizational structure, and capacity for QI in MC plans
- Understand if (and how) MC plans use performance measures for QI
- Identify the strengths and weaknesses of currently used standardized performance measures, such as HEDIS and CAHPS
- Develop questions for a generalizable research study

Research Questions

- Do MCOs use performance measures to improve quality?
- What role do performance measures play in QI activities?
- What characteristics of performance measures make them more or less useful for QI?
- For assisting with QI, what are the strengths and weaknesses of HEDIS and CAHPS?



Study Design and Data Collection

- Exploratory qualitative research using a purposive sample of respondents
- Individual one hour telephone interviews
  - Multiple representatives from 24 health plans (6 plans from each of 4 states)
    - Medical Director
    - Quality Improvement/Assurance Manager
    - President/Chief Executive Officer
- Interviews conducted by two study investigators, tape-recorded, and transcribed

Interview Content

- Confirmation of MCO information
- Respondent's job responsibilities and tenure
- Organization of QI at the plan
- Description of 3 specific QI initiatives
  - origin of initiative
  - specific goals
  - how progress is monitored
  - barriers
  - measurement tools used
- Evaluation of HEDIS and CAHPS as QI tools

Analysis

- Two authors conducted interviews
- Interviews were tape recorded
- Notes drafted by one interviewer and distributed to the other interviewer to verify accuracy
- Notes were used to create a spreadsheet for use in quantitative and qualitative analysis
- Authors discussed findings in several phone conferences
- Findings were obtained by consensus

Study States

- WA State
  - state employees CAHPS demonstration
  - Medicaid
- KS
  - Medicare, Medicaid, and commercial CAHPS demonstrations
- MD
  - CAHPS and HEDIS report for commercial HMOs
- PA
  - HAP HEDIS report
- Pilot State: NJ
  - Medicaid CAHPS demonstration
  - CAHPS and HEDIS report for commercial plans

HMO Enrollment By State

State	Total Managed Care Penetration (%)	Medicare Managed Care Penetration (%)	Medicaid Managed Care Penetration (%)
Kansas	16.8	7.4	49.6
Maryland	46.0	11.6	69.6
Pennsylvania	33.6	27.8	70.2
Washington	17.3	24.4	99.9
National Mean	30.1	17.2	55.6

Plan Selection Criteria

- Enrollment
  - medium and large plans
- Model Type
  - staff and group v. IPA, Network and Mixed
- Potential Bias
  - Potentially more likely to focus on PM & QI because of public reports
  - Bias may be small since HEDIS and CAHPS is widespread

Response

- Overall response rate = 58.3%
- Total of 42 interviews conducted
  - 19 QI directors (79.2%)
  - 15 medical directors (62.5%)
  - 8 CEOs (33.3%)
- 1.8 respondents per plan
- 116 QI initiatives described
- 4 Complete plan refusals (2 PA & 2 MD)

Plan Characteristics

Population	Mean Enrollment	Minimum Enrollment	Maximum Enrollment
Commercial (N=21)	201,394	7,095	851,849
Medicare (N=21)	33,306	1,597	130,251
Medicaid (N=13)	35,647	3,089	82,658

Plan Characteristics

Model Type	Frequency	Proportion
Staff	0	0
Group	4	17%
IPA	12	50%
Network	2	8%
Mixed	6	25%

Insurance Products Offered by Respondent Plans

Plan Product Type	Frequency	Proportion of Plans
HMO	24	100
POS	16	67
PPO	10	42
Indemnity	7	29

Prevalence of Performance Measurement Use

- All MCOs use performance measures for QI, but the degree and sophistication of use vary
- Small non-random sample prevents generalization, but characteristics that should be explored include:
  - affiliation with a large national MCO
  - model type
  - profit status

Role of Performance Measurement for QI

- *Targeting* QI activities
- *Evaluating* current performance
- *Goal setting*
- *Identifying the root cause* of problems
- *Monitoring* QI activities

Range and Variation of Performance Measure Use

- We assessed the range and variability of performance measurement use by examining different ways that plans use measures for similar initiatives
  - Diabetes (11 plans)
  - Asthma (8 plans)
  - Cardiovascular disease (5 plans)

Variation in Content and Focus of Diabetes Programs

- Member Enrollment
  - voluntary, physician referral, nurse initiated via claims
- Ability to Identify Responsible PCP
  - provide PCPs with list of diabetic members
  - require PCPs to report data
  - monitor measurable processes and outcomes
- Contracts with Vendor
  - disease management carve-out programs
  - coordination with pharmacy benefits manager
- Clinical Protocols and Care Planning
- Incentives/Penalties

Measurement Variation in Diabetes Programs

- Decision to Focus on Diabetes
  - HEDIS (64%)
  - Cost and utilization (43%)
  - Prevalence (36%)
  - Others (28%)
- Evaluating Current Performance
  - NCQA's *Quality Compass*
  - Published research studies on best practices
  - ADA guidelines

Variation in Diabetes Programs

- Goal setting
  - Less than 25% could list specific goals (e.g., HbA1c reduction, increased enrollment, etc.)
- Identification of root cause
  - Medical chart review
  - Nurse case managers
  - Member surveys
  - Focus groups
- Strengths/Weaknesses of Measures
  - HEDIS standardization allows regional and national comparisons
  - Data availability (pharmacy, claims) is chief weakness

Characteristics of Useful Performance Measures

- Standardized
- Actionable
- Timely
- Stable and Capable of Trending
- Unit of Analysis
- Affordable and Cost Effective
- Relevant

Value of HEDIS/CAHPS for QI

HEDIS	**Mean Rating (1-5)**
Accuracy (n=34)	3.35
Utility (n=34)	3.56
CAHPS	
Accuracy (n=33)	3.21
Utility (n=32)	3.13

Mean ratings of HEDIS and CAHPS by position

Position	HEDIS mean accuracy rating (1-5)	HEDIS mean utility rating (1-5)	CAHPS mean accuracy rating (1-5)	CAHPS mean utility rating (1-5)
Medical Director	3.35 (n=12)	3.56 (n=12)	3.21 (n=10)	3.13 (n=10)
CEO	3.16 (n=5)	3.34 (n=5)	2.90 (n=5)	2.60 (n=5)
QI Manager	3.40 (n=17)	3.53 (n=17)	3.22 (n=18)	3.32 (n=17)

Mean ratings of HEDIS and CAHPS by state

Position	HEDIS mean accuracy rating (1-5)	HEDIS mean utility rating (1-5)	CAHPS mean accuracy rating (1-5)	CAHPS mean utility rating (1-5)
KS	3.20 (n=9)	3.28 (n=9)	3.00 (n=8)	2.88 (n=8)
MD	3.19 (n=8)	3.63 (n=8)	3.33 (n=9)	3.63 (n=8)
PA	3.75 (n=9)	4.02 (n=9)	3.17 (n=9)	3.03 (n=9)
WA	3.25 (n=8)	3.31 (n=8)	3.36 (n=7)	3.00 (n=7)

Strengths and Weaknesses of HEDIS

- Standardization is beneficial
- Cost of HEDIS is burdensome
- NCQA/HEDIS too rigid for 'true' QI
- Comparability of HEDIS questionable
- Yearly reporting is excessive
- Continuous enrollment criteria difficult for Medicaid populations
- HEDIS measures are dynamically unstable
- Unit of analysis is too broad

Strengths and Weaknesses of CAHPS for QI

- Standardization facilitates comparisons
- Measures are 'not actionable'
  - survey questions are not specific
  - unit of measurement is too broad
- Low response rate is problematic
- PCP surveys are more useful
  - some plans do these as often as quarterly
- Too expensive
  - cost/effectiveness questioned

Policy Implications

- Developers of performance measures should understand the role of measurement for QI and the characteristics of useful measures.
- Does standardized measurement hinder true continuous quality improvement?
- Is the market place providing sufficient incentives to prompt plans to take QI seriously?
- What is the most cost-effective configuration of performance measurement?
- Future research should identify and study plans that are successfully linking measurement to improvement.

Acknowledgements

- Funding
  - RAND sub-contract to Penn State
  - funding from AHRQ (HS09024)
- Respondents
  - from 28 health plans in 5 states
- Feedback and Useful Comments
  - Pamela Farley Short
  - Ron Hays

Articles From This Study

- Scanlon et al. 2000. "Are Managed Care Plans Organizing for Quality?" *Medical Care Research and Review*, Vol. 57 Supplement 2, 9-32.
- Scanlon et al. 2001. "The Role of Performance Measures for Improving Quality in Managed Care Organizations". *Health Services Research* (in press).

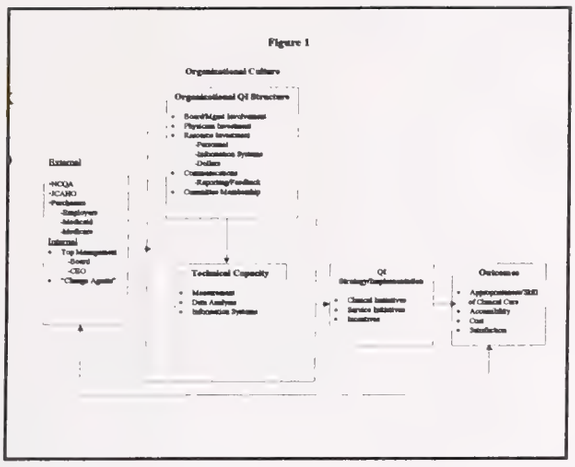
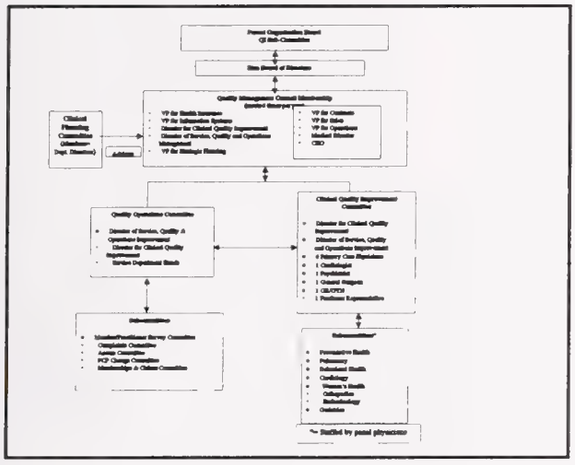


Figure 1
Organizational Culture
Organizational QI Structure
Board/Mgmt involvement
Physician Involvement
Resource Investment
-Personnel
-Information Systems
-Dollars
Communications
-Reporting/Feedback
Committee Membership
External
•NCQA
•JCAHO
•Purchasers
-Employers
-Medicaid
-Medicare
Internal
Top Management
-Board
-CEO
"Change Agents"
Technical Capacity
Measurement
Data Analysis
Information Systems
QI
Strategy/Implementation
Clinical Initiatives
Service Initiatives
Incentives
Outcomes
Appropriateness/Skill of Clinical Care
Accessibility
Cost
Satisfaction


Clinical Quality Improvement Committee
Subcommittees
Staffed by panel physicians

Notes

Notes

No presentation or handout materials were received from Jeanne Mcgee prior to the meeting for inclusion in the handout binder.

No presentation or handout materials were received from Leo Morales prior to the meeting for inclusion in the handout binder.

CAHPS Qualitative Subgroup Analysis Study

- Dealt with Medicare+Choice health plans and the health care needs of four traditionally "vulnerable" populations.
  - Elderly in self-described fair or poor health
  - Disabled < 65 years of age
  - African Americans
  - Hispanics/Latinos

Barents Group of ABCD Consulting, LLC

Research Questions Posed

- What are the specific health care *needs* of each population?
- What are the *barriers* these populations encounter in trying to have their health care needs met?
- What are health plans doing to mitigate or eliminate these barriers?
- What are some realistic "actionable items" that HCFA can recommend that plans implement in order to better address the needs of vulnerable subpopulations?

Barents Group of ABCD Consulting, LLC

Methodology

- Literature reviews
- Site visits to 11 plans (mix of high-scoring/low-scoring CAHPS plans)
- Convening two rounds of Technical Expert Panels
- Conducting beneficiary focus groups

Barents Group of ABCD Consulting LLC

Examples of Actionable Items

	Strategic	Operational
Plans	Identification/stratification of vulnerable populations	Establish community partners, e.g., CBOs, to leverage resources and improve access to services
HCFA	Develop new risk-adjustment or other payment mechanisms to compensate care systems that deliver services to at-risk populations	Sponsor conferences and workshops that highlight innovative care delivery programs

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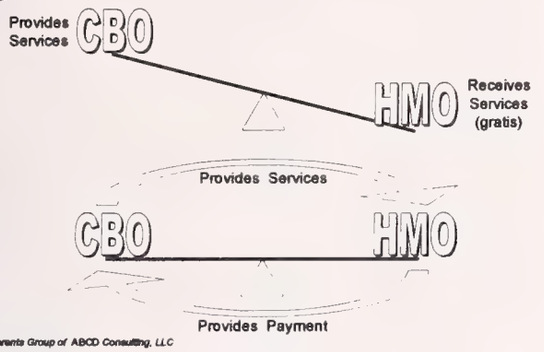
CBO-HMO Relationship



Barents Group of ABCD Consulting, LLC

No presentation or handout materials were received from Lorraine Brown prior to the meeting for inclusion in the handout binder.

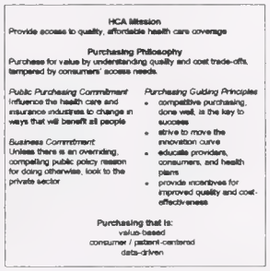
The Washington State Health Care Authority (HCA)
HCA Purchasing and CAHPS

CAHPS User Group Meeting
March 08, 2001

Mary Uyeda, Ph.D.
HCA/Health Policy, Research and Development

CAHPS

Consumers -- Where Consumers Fit in the HCA Purchasing Framework



HCA Mission
Provide access to quality, affordable health care coverage

Purchasing Philosophy
Purchase for value by understanding quality and cost trade-offs, tempered by consumers' access needs.

Public Purchasing Commitment
Influence the health care and insurance industries to change in ways that will benefit all people

Business Commitment
Unless there is an overriding, compelling public policy reason for doing otherwise, look to the private sector

Purchasing Guiding Principles
- competitive purchasing, done well, is the key to success
- strive to move the innovation curve
- educate providers, consumers, and health plans
- provide incentives for improved quality and cost-effectiveness

Purchasing that is:
value-based
consumer / patient-centered
data-driven

Looking at our Mission

- We contract for access … affordable …
- We purchase for value by understanding ...

Quality and Cost Tradeoffs ...

Value = quality/cost

Looking at our business commitment

- We look to the private market
- We believe consumers can push the market

What we've done so far

- Produced CAHPS surveys and reports
- Used CAHPS results in O.E. materials

What has HCA learned?

- If people need information for plan enrollment choices, and the information is available, they will use it
- PEBB enrollees liked the CAHPS consumer survey and report
- PEBB enrollees relate to providers more than health plans
- Enrollees are still learning about managed care
- Subgroups may be interested in different things

Considerations for the next steps

- Focus on health plans, make room for provider-level topics
- Focus on what consumers say they want, educate on some topics
- Target what will help consumers change the market
- Show relationships, make room for customizing
- Show consumers how to apply what they know
- Work for informed consumer**ism**

What are the next steps?

- CAHPS results from contracted Plans
- Education initiatives throughout the year
- Decision Support Tool
- Leapfrog

Where does CAHPS fit?

- Integration into agency communication cycle
- Format and distribution changes to reach diverse audiences
- Using information to make choices

Integration into Agency Communications Cycle

- Open enrollment materials
- Year-round assistance for enrollees
- Educational topics

Format and Distribution Changes

- Use content, design & format principles
- Develop educational topics for enrollees
- Use the CAHPS results throughout the year
- HCA & WA State Web sites

Using Information to Make Choices

- Decision Support Tool by 2002 open enrollment
  - Requesting assistance as well as a product
  - CAHPS results and other performance measures
- Links to on-line enrollment, plan sites and provider directory

What's Next?

- Expand and apply understanding of how consumers process information and make decisions related to health care
- Consider time cycles for using information

What's Next? (2)

- Use the Leapfrog initiative
- Target what will help consumers move the market

The Alliance QualityCounts Medical Group Report
An Evaluation of Consumer Recall and Readership by Distribution Method

About The Alliance

The Alliance is an employer health care purchasing cooperative located in Madison Wisconsin. Our members are large and mid-sized self-funded employers in the thirteen counties in south-central Wisconsin. On behalf of our members, The Alliance has established a broad network of providers; we contract with well over 90% of the hospitals and medical groups in our service area. Freedom of choice is one of our key competitive advantages. Freedom to choose doctors and hospitals makes having access to comparative all the more important.

QualityCounts is The Alliance's program to fulfill our strategy *"to build and sustain a consumer demand for quality"*. Our strategy is founded on our beliefs that:

- Quality varies
- Quality can be measured
- Regular people can understand and use measures of quality to make decisions
- Quality measurement, and the market demand it fosters, will drive health care improvement.

Project Description

We used the group-level CAHPS survey to profile patient perceptions of the 12 medical groups and clinics used most often by our members. The sample frame was drawn from the membership of The Alliance using patient address files that we maintain. We administered the survey to Alliance members who had a primary care visit within the past year. The results were benchmarked against the top scores in the National CAHPS Benchmarking Database.

We developed two versions of a paper report – a brochure style report that included the CAHPS composites and ratings and a more detailed report that included the responses to the individual questions that constitute the composites. We also created an e-mail version and established a website, www.qualitycounts.org, to house the results.

Promotion and Distribution

We implemented a communications campaign that began prior to survey administration and ended almost 12 months after report distribution. The goals of the campaign were to:

- Promote survey completion by Alliance members.
- Create awareness and interest in the results.
- Promote use of the results in provider selection and communication.
- Inform consumers about provider response and use of the results to improve care and service.

The reports were distributed in April 2000. The primary method of distribution was from Alliance member employer to their employees. A small number of reports were also sent to employees directly by The Alliance. In addition, The Alliance established distribution partners including the media, AARP and the public libraries to make the report available to the public at large.

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The Alliance
Employer Health Care Alliance Cooperative

Evaluation

The QualityCounts Medical Group report was evaluated to assess the efficacy of three primary distribution methods and the impact on consumer recall and report readership. The evaluation involved two phases. Phase One evaluated the distribution channel selected by the employer. Phase Two assessed awareness and use of the report by employees, based on the method of distribution.

Phase One – Distribution

Methodology:

Alliance member employers distributed the report in one of three ways (selected by the employer).

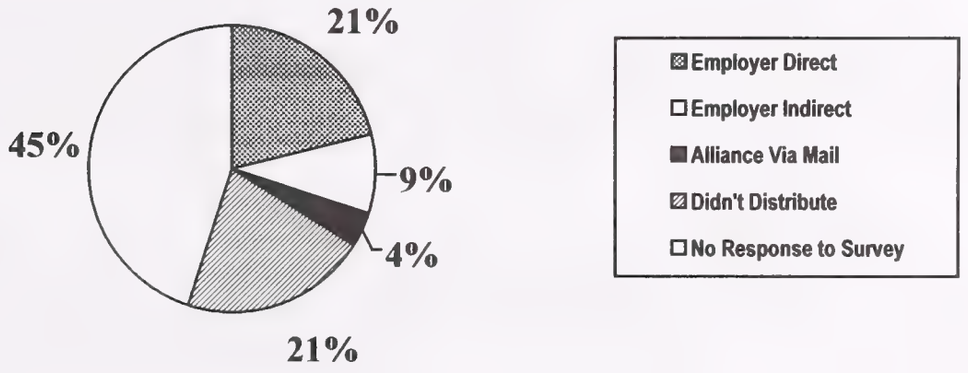
- Employer - Direct = distribution via payroll stuffers, mailed to employees' homes or interoffice mail. Note: an email version of the report was made available for employers to distribute and, while 5 employers expressed a preference for this report, none actually disseminated it to their employees.
- Employer - Indirect = posted in display racks or on bulletin boards, displayed in common areas, distributed to employees only upon request.
- Alliance via mail = distributed by The Alliance to employees' homes using mailing labels supplied by the employer

The report was released in the last week of April 2000. In June, we surveyed Alliance employers to assess the extent to which distribution (from employers to employees) had been accomplished and to solicit feedback from employers on ways to improve the process in the future.

Results:

The survey of employers achieved a 55% response rate.

% of Employers by Distribution Method



Survey Highlights

- 47% (27) used one or more methods to promote the report, such as newsletter articles or payroll stuffers
- 82% (47) were satisfied or very satisfied with the distribution options available to them
- Of those who distributed the report, most have plans for its continued use (e.g. with new hires – 42%; during open enrollment – 16%; at health fairs or benefit meetings – 11%)
- Reasons cited for not distributing the report -
  36 employers had not distributed the report to their employees at the time of the survey. 5 of those employers (14%) cited lack of time as a barrier, but intended to distribute it. The remaining 31 employers cited various reasons, including:

Reason	**%**	***n***
Health plan or workplace complexity —offer too many health plans, have too many locations, unique kind of members (association), too much change internally right now.	25%	*9*
Wasn't expecting the report	11%	*4*
Information is not credible and/or valuable	11%	*4*
Don't believe employees will value/use the report	11%	*4*
Lack of time, don't intend to distribute	8%	*3*
Clinics/medical groups not relevant to my employee group	8%	*3*
Unsure how to distribute it	8%	*3*
Don't remember receiving the report	6%	*2*

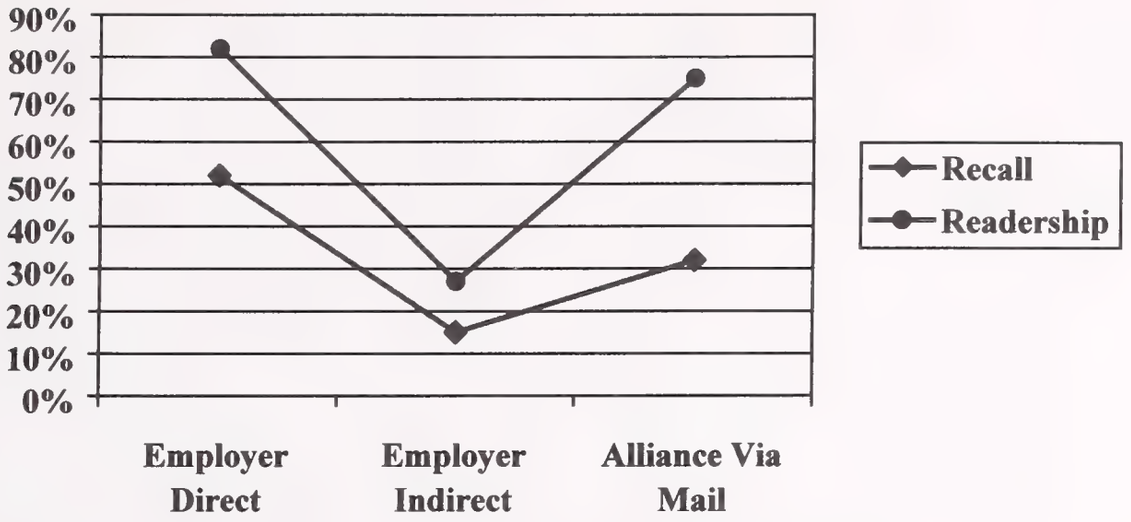
Phase Two – Employee awareness and use

Methodology:

A sample of the employees whose employers distributed the QualityCounts report (directly, indirectly or via The Alliance) were surveyed via telephone in July 2000. The survey was designed to test awareness and use based on each of the three distribution methods identified in Phase One (employer direct, employer indirect and Alliance via mail). The phone survey achieved a response rate of 78%.

Results:

Overall, slightly over one-third could recall receiving the QualityCounts report. Of those that remembered getting the report, 75% said they read it. Recall and readership varied significantly based on the method of distribution.



Of those who were aware of the report but didn't read it, the dominant reasons were "too busy" (44%) or "not interested in the information" (30%).

Take-aways:

- *Importance of the employer role* - The most effective distribution method is "employer direct". Awareness and readership was significantly higher among employees who received the report via this method. We need to "make the business case" for employers to invest in educating their employees about health care quality. We need to clearly demonstrate the return to employers when their employees have information with which to choose high quality health care.

- *Direct link to employees* – The Alliance should establish venues for direct communication with employees. While an engaged employer is the most effective vehicle for communicating with employees, this will not be possible to achieve in all cases. Lack of time and, in some cases, lack of interest will hinder dissemination of comparative quality information. We need to establish communication vehicles to compliment or substitute for those used by employers.

- *Employee interest in comparative information* – It's remarkable that 75% of employees who remember receiving the report, read it. It is also remarkable that the telephone survey to evaluate the report received a 78% response rate. In addition, all employees contacted were asked their interest in participating in a future focus group to provide input on the development of future reports. 92 employees (or 41%) agreed, even though 60% of these would have to travel from outside of the greater Madison area to attend and the meeting would take place in the evening.

Using CAHPS to Measure Access Differences for Publicly Insured Children

Jennifer N. Edwards, DrPH and David Rein, MPA

Georgia Health Policy Center
Andrew Young School of Policy Studies
Georgia State University

Funded by the Georgia Division of Medical Assistance and the United Parcel Service Foundation

Policy Context

- Due to CHIP, increasing numbers of children are now publicly insured, many in managed care settings
- Little is known about how children with special health care needs fare in any managed care setting
- States and HCFA want to know if these children have access to needed care

Research Questions

- Do CSHCN have access to needed health care services?
  - Primary and preventive care
  - Urgent care
  - Specialty care
  - Dental care
- Do CSHCN in Medicaid and CHIP have different experiences?

Hypotheses 1. CSHCN have better access than others

Sicker Children

- More urgency on the part of parents
- More likely to have a relationship with providers and administrators
- Higher compensation for providers
- Parents have more experience with the health care system

Hypotheses 2. CHIP children have better access than Medicaid children

CHIP Children

- More likely to have had private health insurance in the past
- Higher education and income
- Paid premium
- Less stigma
- May have prior relationship with provide
- More acceptable to doctors than Medicaid patients

Alternative Hypotheses

- Medicaid children have better access because:
  - They are sicker (and so more like CSCHN)
  - They access care at teaching facilities
  - They know how to work the system
- CSHCN have worse access because:
  - Extra compensation perhaps is not enough
  - Frequent visits increase probability of experiencing access difficulties

Research Methods

- All measures were drawn from the Consumer Assessment of Health Plans (CAHPS) Survey 2.0 for Medicaid managed care plans
- A random, representative sample of parents were interviewed by mail and phone in February-April, 2000
- Medicaid response rate 54%, CHIP response rate 70%
- N=1585 (MC 1084, CHIP 501)

Research Methods, Part 2

- Logistic regression model used to calculate the probability of different types of care
- Each model tested the effect of Program (MC vs. CHIP) and CSHCN controlling for race, parent education, child's age, and rural location.

CAHPS definition of CSHCN

Yes to Q80 and yes to either Q81 or Q82

Q80: Does your child now have any medical conditions that have lasted or are expected to last at least 3 months?

Q81:In the last 12 months, has your child seen a doctor or other health provider more than twice for any of these conditions?

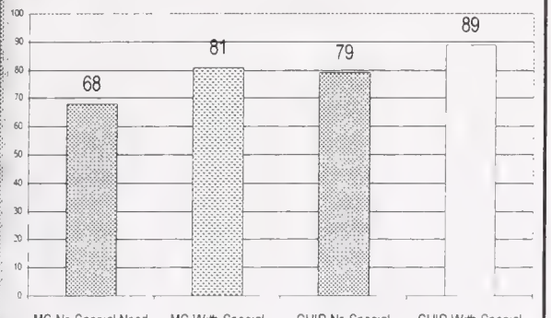
Q82: Has your child been taking prescription medicine regularly for any of these conditions?

- 21% of children in the survey met the criteria of having a special health care need

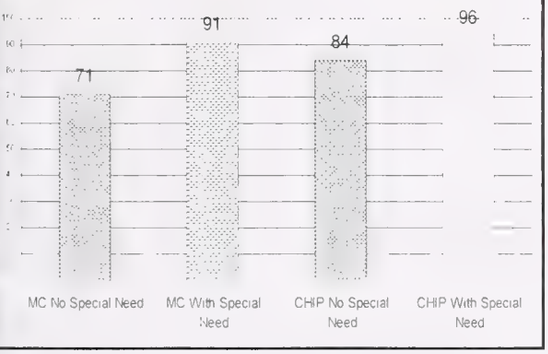
Access Measures/Dependent Variables

- Child had a Primary Care Physician
- Child had at least one doctor visit
- Child did not have a big problem getting a dental appointment, when care was needed
- Child saw a specialist when they needed one
- Child did not have a big problem getting "needed care"

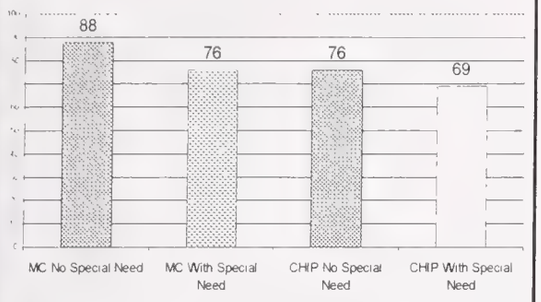
Children with a Primary Care Provider



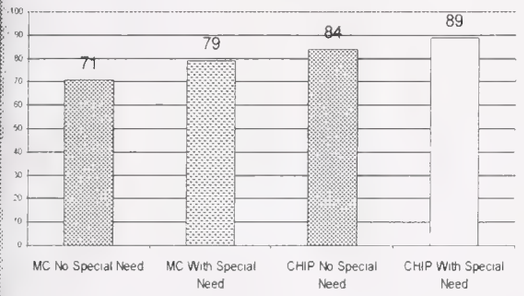
Percent Who Saw A Doctor At Least One Time



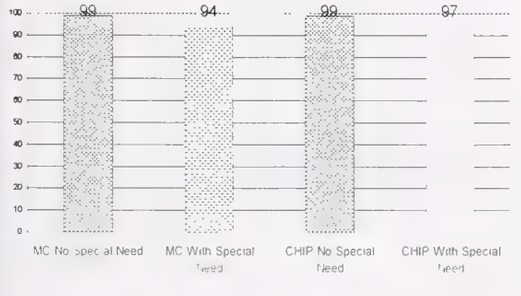
Percent who did not have a big problem getting a dental appointment, when care was needed



Percent of Children Who Saw a Specialist, When Needed



Percent of Children who did not have a big problem getting care parent or doctor thought was necessary



Who Does Better?

Based on regression analysis controlling for age, parent education, and urban rural status

Measure	MC/CHIP	SHCN/ No SHCN
PCP	CHIP p < .05	SHCN p < . 01
Doctor Visit	CHIP p < .01	SHCN p < . 01
Trouble Getting Dental Apt	MC p < .01	No SHCN p < . 01
Needed Specialist Care	Not Significant	Not Significant
Problem getting "needed" Care	Not Significant	No SHCN p < .01
Odds of reporting "Good" or better health	CHIP p < .01	No SHCN p < .01

Access Measures

Odds Ratio, controlling for Race, Parent's Edu, Urban/Rural Status, and Child's age.

	Medicaid No Special Need	Medicaid With Special Need	CHIP No Special Need	CHIP With Special Need
Measure Child Has PCP	0.77 P<.10	1.31	1.00 P<.01	2.46 P < .01
Child Has Seen the Doctor at least once	0.54 P < .01	2.10 P>.01	1.00 P>.01	4.98 P < .01
Did not have a big problem getting a dental Appt.	2.19 P < .01	0.949	1.00 P<.01	0.69
Received specialist Care When Needed	0.62	0.81	1.00 P>.01	1.34
No problem getting "needed" Care	1.76	0.19 P<.01	1.00 P<.01	.446

Summary of GA Findings

- CSHCN have better access on primary care but worse access on specialized services such as dental and "other needed" care.
- CHIP children have better access than Medicaid children except for dental care, despite identical program characteristics.

Caveats

- Could not detect a difference in specialist access due to cell size
- Believe Medicaid children may have better dental access due to experience with the program
- Other variables that might explain population differences are not available

Policy Implications - 1

- Georgia Medicaid and CHIP programs appear to give children with special health care needs access to primary care.
- More needs to be done to assure access to other forms of care for CSHCN.

Policy Implications - 2

- Differences in access between Medicaid and CHIP children point to population differences that need to be considered.
- The gap between parents' perception of need and access to care suggests there is still room for improvement.

Further work on Methodology

- What's the right measure of CSHCN?
- How do parents' reports of access correlate with utilization data?
- How do parents' reports of access correlate with provider expectations of need?
- What is the right level of care?

Children With Special Needs Survey: Eligibility Screening

Terri Bruner, RN, CPHQ
Anne Rogers, RN, BSN
North Carolina Medicaid

Factors Influencing Implementation

- HCFA Interim Criteria
- 1915B Waiver Renewal
- Health Choice (CHIP)
- Administration and analysis of CAHPS by UNC-CH
- NC chosen as test site for Special Needs questions by UMASS
- Results of testing in identification.

PLANNING

- Collaboration of DPA and DMA
- Comparison of Screening Tools
- Administrative Vs. Self-Identification
- Collaboration with Eligibility Section
- Process development for follow-up for self-identifiers
- Education for caseworkers and DSSs

ISSUES DELAYING IMPLEMENTATION

- Mutual agreement between DMA and DPH on screening tool.
- Limitations to length of eligibility application.

RESULTS

- Statewide Implementation
- Change in eligibility forms
- Timely intervention for self-identifiers
- Numbers of SN children reported as of 2/28/01

DMA ADMINISTRATIVE LETTER NO. 09-01

DATE: October 24, 2000

SUBJECT: Children with Special Health Care Needs

DISTRIBUTION: County Directors of Social Services
NC Health Choice/Medicaid Supervisors
NC Health Choice/Medicaid Eligibility Staff
Work First Supervisors and Eligibility Staff

I. BACKGROUND

There are two aspects to identification of children with special health care needs.

A. Identification of Children with Special Health Care Needs who are Enrolled in Medicaid and NC Health Choice

Federal reporting requires that the State report information on children with special health care needs for the managed care waiver. A questionnaire, DMA 5069, has been developed to capture the necessary information. The DMA-5069 will be added at a later date to the application and re-enrollment forms in the Family and Children's program. The DMA-5069 is not an eligibility requirement in determining eligibility for Medicaid, NC Health Choice, and Work First.

This letter provides interim procedures for identifying children with special health care needs. EIS allows workers to enter Special Use code, SN. The Special Use code is a joint indicator for reporting requirements for Work First, Medicaid and NC Health Choice.

B. Waiving the two-month Waiting Period for NC Health Choice Enrollment

The General Assembly passed a law that waives the two-month waiting period for NC Health Choice for Children for some children with special health care needs identified through the DMA 5069, who are covered by comprehensive health insurance. For the waiting period to be waived a doctor must state on a DMA-5068 that the child has at least one of the following conditions:

- Birth defect, including genetic, congenital or acquired disorders
- Developmental disability
- Mental or behavioral disorder
- Chronic and complex illness

These conditions are expected to continue at least 12 months, interfere with the child's daily routine and require extensive medical intervention and family management. Form

DMA-5068 has been developed for the doctor to sign and for the parent to document insurance has stopped or will stop.

The waiting period still applies to all children whose families voluntarily discontinue health insurance coverage when a doctor has not stated the child has one of these conditions.

The provisions of the law are applicable to applications taken on or after November 1, 2000 and to re-enrollments mailed or scheduled on or after November 1, 2000.

II. PROCEDURES FOR IDENTIFYING CHILDREN WITH SPECIAL HEALTH CARE NEEDS FOR MEDICAID AND NC HEALTH CHOICE

A. Applications

For every Family and Children's Medicaid, Work First and Health Choice application complete the DMA-5069 *Special Health Care Needs Questionnaire* (Attachment 1).

- **Ensure that the DMA-5069 is completed when the application is made in the office.**

- **If clients call requesting an application attach the DMA-5069 to the application before mailing it. For applications located at health departments or other outstations, send the DMA-5069 to these agencies and ask them to make copies and to attach to each application before distributing to clients. Also do this for any applications placed at the reception desk or other areas of the county dss.**

1. **Interim Procedures until the DMA-5069 is added to the application form.**

   a. Mail the DMA-5069 to all applicants who have applied by mail or at health departments for the Medicaid and NC Health Choice programs and the date of application is November 1, 2000 or later. One side of the DMA-5069 is a letter to the parent/guardian, briefly explaining the DMA-5069. Address the letter to the applicant and include worker's name and telephone number. Give a 10 calendar day deadline for its return.

      (1) If the DMA-5069 is not returned by the deadline the worker processes the application following all eligibility requirements. Do not hold the application waiting for the DMA-5069.

      (2) If the client returns the DMA-5069 see 2. below.

   b. The DMA-5069 is not an eligibility requirement in determining eligibility for Medicaid, NC Health Choice and Work First.

   c. Always file the DMA-5069 in the record.

2. If the DMA-5069 is returned and the caretaker responds yes to both questions in at least one of the boxes (for example question 1 and 1a answered yes) the child has special health care needs.

If the DMA-5069 is returned and both questions in a box (for example 1 and 1a) are checked yes, and there is no child's name listed, call the client to get the name of the child. If you are unable to reach the client by phone, mail the form to him asking him to write in the name of the child and return it to you as soon as possible.

3. Do not attempt to contact the client if only one question in a box is answered yes and the other is blank, or if the parent did not sign the form. No action is required in EIS.

4. If the DMA-5069 shows a child has special health care needs, enter EIS Special Use code SN in the individual section of the DSS-8125 to indicate special health care needs for that child.

   a. Enter a From Date which is the first day of the month in which the DMA-5069 was received. The format for the date is mmddyy.

   b. Enter a Thru Date which is the last day of the certification period or payment review period for Work First. The format for the date is mmddyy.

      Example: Certification period is 10/01/2000 through 09/30/2001 and the DMA-5069 is returned on 11/03/2000. The entry should be: SN 110100093001.

B. Re-Enrollments (Interim procedures until the DMA-5069 is added to re-enrollment forms)

1. Send the DMA-5069 and a return addressed envelope to all mail-in re-enrollments for MAF, MIC, NC Health Choice and Work First once the re-enrollments are received. Allow at least 10 calendar days for the return of the DMA-5069.

   For those redeterminations conducted in the office, complete the DMA-5069 during the interview.

2. If the DMA-5069 is not returned by the deadline, process the re-enrollment following applicable eligibility requirements. The DMA-5069 is not an eligibility requirement.

3. If the DMA-5069 is returned and is complete, process the re-enrollment following applicable eligibility requirements.

   a. If the DMA-5069 is returned and the caretaker responds yes to both questions in one of the boxes (for example question 1 and 1a answered yes) the child has special health care needs.

   b. If the DMA-5069 is returned and both questions in a box (for example 1 and 1a) are checked yes, and there is no name listed, call the client to get the name of the child. If you are unable to reach the client by phone, mail the DMA-5069 to him asking him to write the name of the child and return to you as soon as possible.

c. Do not attempt to contact the client if only one question is answered yes and the other is blank, or if the parent did not sign the DMA-5069. No action is required in EIS.

d. File the DMA-5069 in the record.

4. Refer to II.A.4. on how to enter the Special Use code, SN.

III. WAIVING THE WAITING PERIOD FOR NC HEALTH CHOICE CHILDREN WITH SPECIAL HEALTH CARE NEEDS WHO HAVE HEALTH INSURANCE

A. Identifying NC Health Choice Cases with a Waiting Period

When the DMA-5069 is returned determine if a waiting period applies for a child covered by comprehensive health insurance who has special health care needs and appears eligible for NC Health Choice. If the child has been insured within the past two months a waiting period may apply. Refer to MA-3225 for exceptions to the waiting period.

1. If the family has no medical insurance or the insurance was discontinued more than two months ago, file the DMA-5069 in the case record. Refer to II.A.4. on how to enter the Special Use code SN.

2. If a waiting period applies or a child still has comprehensive insurance in effect, send the *Verification of Special Health Care Needs,* DMA-5068, (attachment 3) along with the letter of explanation (attachment 2) to the family for each child indicated on the DMA-5069 to have special health care needs. A copy should be retained in the record to indicate it was sent.

B. Disposition of Applications

Give the family at least ten calendar days to return the DMA-5068 with the physician's signature, and the parent's statement that insurance is terminated. If ten calendar days exceed the 45 day processing period, pend until the first workday after the due date for the form.

1. If the DMA-5068 is not returned deny the application because the child has health insurance. If the client has indicated that the insurance has terminated and if the child is otherwise eligible, approve the application effective the month following the two-month waiting period.

2. Approve the NC Health Choice application if the DMA-5068 is returned with the doctor's signature verifying one or more of the listed conditions and the parent's statement that insurance coverage is terminated or is in the process of termination. Do not apply a waiting period.

   Approve NC Health Choice the first of the month following the last day of health insurance coverage. The Certification From Date must be the same as the Medicaid Effective Date. Advise clients that health insurance coverage must end on the last day of the month or the child may be without any coverage for a certain period of

time. If you later learn that insurance has not terminated, terminate NC Health Choice allowing timely notice.

a. If the insurance ends the month the 45th day falls, approve the application the first of the month following the last day of health insurance coverage. If the DMA-5068 is returned prior to the effective date, use the month NC Health Choice is effective as the month special needs begins.

b. If the insurance doesn't terminate until the month after the 45th day, deny the application. Advise the family to reapply.

C. NC Health Choice Re-enrollments

For NC Health Choice re-enrollments, if the DMA-5069 is returned indicating a child has special health care needs, do not send the DMA-5068 unless there is a question that the child now has health insurance or that the family may have dropped insurance. Since this should be rare, the DMA-5068 is not required. If the family requests assistance for a child not previously in the case and the DMA-5069 indicates child has special health care needs, send the family the DMA-5068.

Refer to II.A.4. on how to enter the Special Use code, SN.

Please make copies of these forms to use until supplies can be ordered. Send forms to the health departments or other outreach locations to be attached to applications they have in supply.

If you have any questions, please contact your Medicaid Program Representative.

Paul R. Perruzzi
Director

[This material was researched and written by Dora Boissy, Policy Consultant, Medicaid Eligibility Unit.]

_____
Date

Dear_____
(Parent/Guardian)

Federal law requires that North Carolina identify children with special health care needs. The purpose of the questionnaire on back of this form is to identify these children. Please read questions 1-5 and answer all the questions. If you answer yes to any two questions in any of the boxes, write the name(s) of the child(ren) on the spaces provided. Sign and date the questionnaire. Return the form to the Department of Social Services by mail or in person. If you have questions about this form, call your worker or the department of social services.

_____
Worker

_____
Telephone number

SPECIAL HEALTH CARE NEEDS QUESTIONNAIRE

Please answer the questions below and return this form to the department of social services.

Parent/Guardian *(Please print)* _____

For office use only

Date _____ Due Date _____ Co. Case No. _____ Worker _____

1 *Does your child(ren) currently need medicine prescribed by a doctor other than vitamins?* _____*yes* _____*no.*

1a *Does your child(ren) need this medicine because of ANY medical, behavioral or other health condition that has lasted or is expected to last at least 12 months* _____*yes* _____*no.*

If you answered yes, name the child(ren) _____

_____

2 *Does your child(ren) need more medical care, mental health or educational services than usual or routine for most children of the same age? yes* _____*no* _____.

2a *Does your child(ren) need these services because of ANY medical, behavioral or health condition that has lasted or is expected to last at least 12 months?* _____*yes* _____*no.*

If you answered yes, name the child(ren) _____

_____

3 *Is your child(ren) limited or prevented in any way in his/her ability to do the things most children the same age can do?* _____*yes* _____*no.*

Is this because of ANY medical, behavioral or other health condition that has lasted or is expected to last at least 12 months? _____*yes* _____*no.*

If you answered yes, name the child(ren) _____

_____

4 *Does your child need special therapy, such as physical, occupational or speech therapy?* _____*yes* _____*no.*

4a *Does your child need this therapy because of ANY medical, behavioral or other health condition that has lasted or is expected to last at least 12 months?* _____*yes* _____*no.*

If you answered yes, name the child(ren) _____

_____

5 *Does your child(ren) currently have any kind of emotional, developmental or behavioral difficulty for which he or she needs treatment or counseling?* _____*yes* _____*no.*

5a *Does your child need this treatment or counseling because of ANY medical, behavioral or other health condition that has lasted or is expected to last at least 12 months?* _____*yes* _____*no.*

If you answered yes, name the child(ren) _____

_____

Signature _____ *Date* _____

Parent/Guardian

DMA-5069 (11/00)

Date:_____ Worker:_____ Telephone:_____

Dear_____
(Parent/Guardian)

The attached form will allow your child with special health care needs to enroll in NC Health Choice for Children, even if he or she currently has health insurance and you want to switch to NC Health Choice.

NC Health Choice for Children is a health insurance program for children. To be eligible for Health Choice, a family normally must show that their child has been without insurance for at least two months. We require this waiting period to make sure that Health Choice is available to those children who need it the most. This means that children who have no insurance can enroll immediately while those who already have insurance but want to change insurance companies will have a waiting period.

Effective November 1, 2000, a special exception to the two month uninsured waiting period can be made for families with a child with special health care needs. This will allow a child with special health care needs to stop his current health insurance coverage and move to Health Choice without a waiting period and without a lapse in coverage. A doctor will help you decide if this special exception applies to your child.

If you decide that your child would benefit by moving from your private insurance to Health Choice, you must be sure to carefully follow the steps below. Complete each step before moving on to the next step. Following these steps will help you make sure that your child is covered by insurance *at all times* as you switch policies.

_____ 1. You have already completed the Health Check/Health Choice application form and submitted the required documents (paychecks for four weeks or one month). This was Step 1.

_____ 2. You have received this letter and the attached form because you indicated on the application questionnaire that your child has special health care needs and has private insurance.

_____ 3. As soon as possible, take this form to your child's doctor for his/her signature.

_____ 4. Once the doctor has signed your form, notify your current insurance company of your wish to drop your child's health insurance coverage. Make sure they understand that the current coverage must end on the last day of the month. Health Choice coverage will begin on the first day of the next month.

_____ 5. Return this form to the Department of Social Services in your county by mail or in person before_____.

_____ 6. When a decision is made on your application you will be notified by letter. If approved, several days later you will receive your child's ID card and benefits handbook by mail.

If you have questions or need more information, please call the ***Help Line for Children with Special Health Care Needs*** at 1-800-737-3028.

VERIFICATION OF SPECIAL HEALTH CARE NEEDS - FOR NC HEALTH CHOICE FOR CHILDREN

The purpose of this form is to verify that the child listed below has a medical condition which classifies him or her as a child with special health care needs. This information is needed to process the child's application for assistance through the NC Health Choice for Children program.

EIS Case ID_____**Co Case Number**_____**Worker**_____

Casehead: _____ **County Case Number:** _____

Name of Child: _____ **Date of Birth:** _____

For the parent/guardian: Please check the reason for termination of your child's health insurance.

My child's health insurance benefits have been terminated: _____
(please check one) *Date Terminated*

- ☐ **Because my child has a long-term disability.**
- ☐ **Because my child's medical benefits have been substantially reduced or limited.**
- ☐ **Because my child's health insurance benefit category is limited.**

If the insurance is still effective, when will it stop?_____
To insure no lapse in coverage, **terminate insurance the last day of the month.**

Parent/Guardian_____ _Date_____
Signature

Physician: Please complete the following information for the child listed above. Indicate if the child has one or more of the following conditions which is likely to continue indefinitely, interferes with daily activity, and requires extensive medical care and family management of the child's illness. Thank you for your assistance.

- ☐ **Birth Defect - including genetic, congenital or acquired disorders**
- ☐ **Developmental disability**
- ☐ **Mental or behavioral disorder**
- ☐ **Chronic and complex illnesses**

Brief description of diagnosis:_____

_____

_____

Physician's Signature_____ **Date:** _____

DMA-5068 (11/00)

The Experience of Care and Health Outcomes Survey (ECHO™)

A survey to elicit consumers' ratings of their behavioral health treatment, plan, and outcomes.

Background

- NCQA & BHMAP recognized the need for a standard survey
- CABHS and MHSIP surveys identified as best models
- ECHO development group formed to develop a single survey

ECHO Development Group

Consumers (NAMI)	CAHPS & CABHS
NCQA	AMBHA
Washington Circle Group	BHMAP
CMHS (NIMH)	Clinicians/BH experts
MHSIP	Human Services Research Inst.

Development Process

- Study conducted to identify the best aspects of the MHSIP & CABHS surveys
- CABHS-MHSIP comparison results reviewed by the CAHPS instrument team and ECHO development group
- After literacy and cognitive testing, initial ECHO was finished in March 2000

Current Version of ECHO

- 85 items
- Includes core CAHPS questions plus behavioral health specific items
- Literacy level between 7th and 8th grade
- Available in Spanish

Features of CAHPS adopted

- Screener questions used to identify relevant questions
- Ratings & reports collected using 0-10, yes/no, and never – always response options
- Survey formatted in two columns

Content

- Access to treatment
  - e.g. getting an appointment as soon as you wanted
- Communication with clinicians & Staff
  - e.g. did the people you went to for counseling or treatment listen carefully to you

Content

- Plan Administrative Services
  - e.g. understanding written materials
- Global Treatment & Plan Ratings
- Demographic characteristics

New Content Areas

- Family involvement
  - e.g. involving family or friends in the treatment
- Patient Rights & Confidentiality
  - e.g. given information about patient rights
  - e.g. information was kept private

New Content Areas

- Cultural competence
  - e.g. language, race, religion, ethnic background or culture
- Discussion of medications
  - e.g. side effects; told about different medications

New Content Areas

- Perceived treatment current health and treatment effectiveness
  - e.g. rating of ability to deal with daily problems
  - e.g. compared to a year ago, ability to deal with daily problems

Sampling & Administration Protocol

- Survey focuses on those who have received specialty behavioral health services in past year
  - Behavioral health services used by a low percentage of plan members
- Current protocol is similar to the HEDIS/CAHPS method of mail with telephone follow-up

Ensuring Confidentiality

- Use a mixed sample of plan members who have and have not used services
- De-identify sample before release to survey vendor
- Mixed sample allows more sensitive member contact materials

Response Rates

- Survey length does not affect response rates
- Response rates are lower than for CAHPS

	Public Assistance	Commercial
Mail Return Rate (1 mailing)	18%	21%
Telephone Interviews	23%	38%
Overall Returns	41%	59%

Reasons for Non-response

Reason:	Public Assistance	Commercial
Inadequate contact info	33%	18%
Refusal	15%	13%
Too ill	2%	3%
Other	10%	15%

Characteristics of Non-respondents

- Patients with fewer visits
- Patients with an inpatient stay
- Younger patients

Telephone Follow-up

- Increases response rate
- Increases the representativeness of sample for both public assistance and commercial respondents

Effects of Response Task

- Agree - disagree response task prone to mode effects
- Respondents tend to provide the most negative or last response option more often with agree – disagree response task

Effects of Response Task

Percent of items for which most negative response choice is chosen more often by phone than mail respondents

Response Choices	Percent using most negative response more often
Strongly agree – strongly disagree	60% (24 of 40)
Never – Always, 0-10 or yes/no	8.3% (2 of 24)

Identifying Users

- Self report of behavioral health service use in the past 12 months is often inaccurate
  - 17% of those who received services in the past 12 months say they did not
  - Those with more visits are more likely to report service use

Identifying Users

- Those who report 'Excellent' mental health status less likely to report service use
- Those with longer time since most recent visit less likely to report service use

Effect of "screener" Questions

	Percent reporting no outpatient visits	Percent reporting not taking medications
Inapplicable response choice only	2%	15%
Inapplicable Response choice & screener item	15%	40%

Effect of "screener" Questions

Item	Response Choice	Those with experience	Those without experience who answer anyway
Get help over phone	Never	6%	54%
Problem with paperwork	Not a Problem	36%	77%
Told about medication risks	No	10%	55%

Effect of "screener" Questions

	Item Non-response Rate		
	<5%	5-10%	>10%
Inapplicable response choice only	52% 21 of 40 items	48% 19 of 40 items	0
Inapplicable Response choice & screener item	29% 7 of 24 items	63% 15 of 24 items	8% 2 of 24 items

Field Test

- 10 organizations including two states & AMBHA and its members
- Administration methods: mail only, phone only, mail and phone, and internet

NCQA & ECHO:

- NCQA currently encourages MBHO's to use ECHO for MBHO accreditation
- NCQA hopes to recommend the survey as an MBHO accreditation requirement this year
- NCQA may consider the survey as a HEDIS measure in 2002

Other Testing

- New Jersey will survey commercial members of its 7 largest HMOs. The state will survey 8,400 users and 2,100 non-users beginning in April 2001.
- NCQA will test an internet administration protocol in 2001.

Other Testing

- FEHBP parity study will use the ECHO in 2001
- Vermont might mandate ECHO for use by MBHOs
- Maryland might collect ECHO on health plans in 2001

Schedule:

March 25, 2001

New version of ECHO

Summer, 2001

Final administration protocol

ECHO™ Survey

Field Test Version

August 29, 2000

Does not include supplemental first page for mixed user/non-user samples

Experience of Care and Health Outcomes Survey

Sponsored by

[Sponsor Name]

All information that would let someone identify you or your family will be kept private.
[Sponsor Name] will not share your personal information with anyone without your OK.
You may choose to answer this survey or not. If you choose not to, this will not affect the benefits you get.

If you want to know more about this study, please call 1-800-999-9999.

SURVEY INSTRUCTIONS

- Answer <u>all</u> the questions by checking the box to the left of your answer.

- You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

  1☑ Yes ∅ **If Yes, Go to Question 1**
  2☐ No

PERSONAL OR FAMILY COUNSELING

People can get counseling or treatment for many different reasons, such as:

- **For feeling depressed, anxious, or "stressed out"**
- **Personal problems (like when a loved one dies or when there are problems at work)**
- **Family problems (like marriage problems or when parents and children have trouble getting along)**
- **Needing help with drug or alcohol use**
- **For mental or emotional illness**

1. In the last 12 months, did you get counseling or treatment for any of these reasons?

1☐ Yes ∅ **If Yes, Go to Question 2**
2☐ No ∅ **If No, Go to Question 81 on page 11**

YOUR COUNSELING AND TREATMENT IN THE LAST 12 MONTHS

For these questions, please include all counseling or treatment you got in the last 12 months except what you got during an overnight stay or from a self-help group.

2. At any time in the last 12 months, did you need to get counseling or treatment <u>right away</u>?

1☐ Yes
2☐ No ∅ **If No, Go to Question 4**

3. In the last 12 months, when you needed to get counseling or treatment <u>right away</u>, how often did you see someone as soon as you wanted?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always
0☐ I didn't need counseling or treatment right away in the last 12 months

4. In the last 12 months, did you ever make an <u>appointment</u> for counseling or treatment?

1☐ Yes
2☐ No ∅ **If No, Go to Question 6**

5. In the last 12 months, how often did you get an <u>appointment</u> for counseling or treatment <u>as soon as you wanted</u>?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always
0☐ I didn't make any appointment in the last 12 months

6. **In the last 12 months, did you call someone to get professional counseling or treatment for yourself over the phone?**

- 1☐ Yes
- 2☐ No ∅ **If No, Go to Question 8**

7. **In the last 12 months, how often did you get the help or advice you needed over the phone?**

- 1☐ Never
- 2☐ Sometimes
- 3☐ Usually
- 4☐ Always
- 0☐ I didn't call for help or advice in the last 12 months

8. **In the last 12 months, how many times did you go to an emergency room or crisis center to get counseling or treatment for yourself?**

- 0☐ None
- 1☐ 1 time
- 2☐ 2 times
- 3☐ 3 times or more

9. **In the last 12 months (not counting emergency rooms or crisis centers), how many times did you go to an office, clinic, or other treatment program to get counseling or treatment for yourself?**

- 0☐ None ∅ **If None, Go to Question 51 on page 7**
- 1☐ 1 to 10 times
- 2☐ 11 to 20 times
- 3☐ 21 times or more

10. **In the last 12 months, did you call or talk with office staff at any of the places you went to get counseling or treatment?**

- 1☐ Yes
- 2☐ No ∅ **If No, Go to Question 13**

11. **In the last 12 months, how often did the office staff you talked with treat you with courtesy and respect?**

- 1☐ Never
- 2☐ Sometimes
- 3☐ Usually
- 4☐ Always
- 0☐ I didn't call or talk with office staff in the last 12 months

12. **In the last 12 months, how often were the office staff you talked with as helpful as you thought they should be?**

- 1☐ Never
- 2☐ Sometimes
- 3☐ Usually
- 4☐ Always
- 0☐ I didn't call or talk with office staff in the last 12 months

13. **In the last 12 months, how often did you wait at any of the places you went for counseling or treatment more than 15 minutes past your appointment time?**

- 1☐ Never
- 2☐ Sometimes
- 3☐ Usually
- 4☐ Always

The next questions are about <u>all</u> the counseling or treatment you got in the last 12 months during office, clinic, and emergency room <u>visits</u> as well as <u>over the phone</u>. *Please do the best you can even if you went to different people for counseling or treatment.*

14. In the last 12 months, how often did the people you went to for counseling or treatment <u>listen carefully to you</u>?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

15. In the last 12 months, how often did the people you went to for counseling or treatment <u>explain things</u> in a way you could understand?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

16. In the last 12 months, how often did the people you went to for counseling or treatment show <u>respect for what you had to say</u>?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

17. In the last 12 months, how often did the people you went to for counseling or treatment <u>spend enough time</u> with you?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

18. In the last 12 months, how often did the people you went to for counseling or treatment act as though they thought you could improve?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

19. In the last 12 months, how often did you feel safe when you were with the people you went to for counseling or treatment?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

20. In the last 12 months, were you told about any medications, different from those you may already be taking, that might be helpful in your treatment?

1☐ Yes
2☐ No

21. In the last 12 months, have you taken any prescription medications as part of your treatment?

1☐ Yes
2☐ No ∅ **If No, Go to Question 25**

22. In the last 12 months, were you told what side effects of those medications to watch for?

1☐ Yes
2☐ No
0☐ I didn't take any prescription medication in the last 12 months

23. **In the last 12 months, did you experience any side effects from these medications?**

1☐ Yes
2☐ No ∅ **If No, Go to Question 25**

24. **Were any changes made to your medications to reduce or get rid of these side effects?**

1☐ Yes
2☐ No

25. **In the last 12 months, how often were you <u>involved as much as you wanted</u> in your counseling or treatment?**

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

26. **In the last 12 months, did anyone talk to you about whether to include your family or friends in your counseling or treatment?**

1☐ Yes
2☐ No

27. **In the last 12 months, how much were you helped by the counseling or treatment you got?**

1☐ Not at all
2☐ A little
3☐ Somewhat
4☐ A lot

28. **In the last 12 months, were you told about self-help groups, such as consumer-run groups or 12-step programs?**

1☐ Yes
2☐ No

29. **In the last 12 months, were you given information about different kinds of counseling or treatment that are available?**

1☐ Yes
2☐ No

30. **In the last 12 months, were you given as much information as you wanted about what you could do to manage your condition?**

1☐ Yes
2☐ No

31. **In the last 12 months, did the people you went to for counseling or treatment do any tests or assessments with you?**

1☐ Yes
2☐ No ∅ **If No, Go to Question 33**

32. **In the last 12 months, were you told about the results of these tests or assessments?**

1☐ Yes
2☐ No

33. In the last 12 months, were you given information about your rights as a patient?

1☐ Yes
2☐ No

34. In the last 12 months, did you feel you could refuse a specific type of medication or treatment?

1☐ Yes
2☐ No

35. In the last 12 months, how often did you feel comfortable raising any issues or concerns you had about your counseling or treatment?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

36. In the last 12 months, were you always confident that the people you went to for counseling or treatment kept the information about you private?

1☐ Yes
2☐ No

37. We want to know your rating of <u>all</u> your counseling or treatment in the last 12 months.

Use <u>any number from 0 to 10</u> where 0 is the worst counseling or treatment possible, and 10 is the best counseling or treatment possible. How would you rate <u>all</u> your counseling or treatment?

☐ 0 Worst counseling or treatment possible
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10 Best counseling or treatment possible

**** Optional: Insert additional questions about counseling or treatment services here.***

38. In the last 12 months, was there one person who provided most of your counseling or treatment?

1☐ Yes
2☐ No ∅ **If No, Go to Question 40**

39. We want to know your rating of the person who provided <u>most</u> of your counseling or treatment.

Use <u>any number from 0 to 10</u> where 0 is the worst possible and 10 is the best possible. How would you rate the person who provided <u>most</u> of your counseling or treatment?

- ☐ 0 Worst possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best possible

98☐ I don't have one person who provides most of my counseling or treatment

40. In the last 12 months, how much of a problem, if any, was it to get all the counseling or treatment you thought you needed?

1☐ A big problem
2☐ A small problem
3☐ Not a problem

41. How would you rate your ability to deal with daily problems <u>now</u>?

1☐ Excellent
2☐ Very good
3☐ Good
4☐ Fair
5☐ Poor

42. <u>Compared to 12 months ago</u>, how would you rate your ability to deal with daily problems <u>now</u>?

1☐ Much better
2☐ A little better
3☐ About the same
4☐ A little worse
5☐ Much worse

43. How would you rate your ability to deal with crisis situations <u>now</u>?

1☐ Excellent
2☐ Very good
3☐ Good
4☐ Fair
5☐ Poor

44. <u>Compared to 12 months ago</u>, how would you rate your ability to deal with crisis situations <u>now</u>?

1☐ Much better
2☐ A little better
3☐ About the same
4☐ A little worse
5☐ Much worse

45. How would you rate your ability to deal with social situations <u>now</u>?

1☐ Excellent
2☐ Very good
3☐ Good
4☐ Fair
5☐ Poor

46. Compared to 12 months ago, how would you rate your ability to deal with social situations now?

1☐ Much better
2☐ A little better
3☐ About the same
4☐ A little worse
5☐ Much worse

47. How would you rate your ability to accomplish the things you want to do now?

1☐ Excellent
2☐ Very good
3☐ Good
4☐ Fair
5☐ Poor

48. Compared to 12 months ago, how would you rate your ability to accomplish the things you want to do now?

1☐ Much better
2☐ A little better
3☐ About the same
4☐ A little worse
5☐ Much worse

49. Does your language, race, religion, ethnic background or culture make any difference in the kind of counseling or treatment you need?

1☐ Yes
2☐ No ∅ **If No, Go to Question 51**

50. In the last 12 months, was the care you received responsive to those needs?

1☐ Yes
2☐ No

YOUR HEALTH PLAN FOR COUNSELING OR TREATMENT

The next questions ask about your experience with your health plan for counseling or treatment in the last 12 months.

51. Are you now in [Plan Name]?

1☐ Yes ∅ **If Yes, Go to Question 53**
2☐ No

52. What is the name of your health plan now? (Please print)

0☐ None ∅ **If None, Go to Question 81**

Plan Name: _____

53. Is this the health plan that you use for all or most of your counseling or treatment?

1☐ Yes
2☐ No

54. How many months or years in a row have you been in this health plan?

1☐ Less than 12 months
2☐ 12 up to 24 months
3☐ 2 up to 5 years
4☐ 5 up to 10 years
5☐ 10 or more years

55. How much of the counseling or treatment you got in the last 12 months was paid for by your health plan?

1☐ All of it was paid for
2☐ Some of it was paid for
3☐ Very little of it
4☐ None of it was paid for

56. **In the last 12 months, did <u>your health plan stop paying</u> for counseling or treatment because you had used all your benefits?**

1☐ Yes
2☐ No ∅ **If No, Go to Question 59**

57. **At the time your health plan stopped paying, did you think you <u>still needed</u> counseling or treatment?**

1☐ Yes
2☐ No ∅ **If No, Go to Question 59**

58. **Did anyone from your health plan tell you about <u>other ways</u> to get counseling, treatment, or medication?**

1☐ Yes
2☐ No

59. **When you joined your health plan or at any time since then, did you get someone <u>new</u> for counseling or treatment?**

1☐ Yes
2☐ No ∅ **If No, Go to Question 61**

60. **With the choices your health plan gave you, how much of a problem, if any, was it to get someone you are happy with?**

1☐ A big problem
2☐ A small problem
3☐ Not a problem
0☐ I didn't see someone new for counseling or treatment

61. **In the last 12 months, how much of a problem, if any, were delays in counseling or treatment while you waited for approval from your health plan?**

1☐ A big problem
2☐ A small problem
3☐ Not a problem

62. **<u>Paperwork</u> means things like getting your ID, having your records changed, or filling out forms.**

In the last 12 months, did you have any paperwork about counseling or treatment to do for your health plan?

1☐ Yes
2☐ No ∅ **If No, Go to Question 64**

63. **In the last 12 months, how much of a problem, if any, did you have with paperwork for your health plan?**

1☐ A big problem
2☐ A small problem
3☐ Not a problem
0☐ I didn't have any experiences with paperwork for my health plan in the last 12 months.

64. **In the last 12 months, did you look for any <u>information in written materials</u> about counseling or treatment from your health plan?**

1☐ Yes
2☐ No ∅ **If No, Go to Question 66**

65. **In the last 12 months, how much of a problem, if any, was it to find or understand information in the written materials?**

- 1☐ A big problem
- 2☐ A small problem
- 3☐ Not a problem
- 0☐ I didn't look for information from my health plan in the last 12 months.

66. **In the last 12 months, did you call your health plan's customer service to get information or help about counseling or treatment?**

- 1☐ Yes
- 2☐ No ∅ **If No, Go to Question 68**

67. **In the last 12 months, how much of a problem, if any, was it to get the help you needed when you called your health plan's customer service?**

- 1☐ A big problem
- 2☐ A small problem
- 3☐ Not a problem
- 0☐ I didn't call my health plan's customer service in the last 12 months.

68. **We want to know your rating of all your experience with your health plan for counseling or treatment.**

Use any number from 0 to 10 where 0 is the worst health plan possible, and 10 is the best health plan possible. How would you rate your health plan?

- ☐ 0 Worst health plan possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best health plan possible

* ***Optional: Insert additional questions about health plan for counseling or treatment services here.***

69. **In the last 12 months, what effect has the counseling or treatment you got from your plan had on your symptoms or problems?**

- 1☐ Very helpful
- 2☐ A little helpful
- 3☐ Not helpful or harmful
- 4☐ A little harmful
- 5☐ Very harmful

70. **In the last 12 months, what effect has the counseling or treatment you got from your plan had on the quality of your life?**

- 1☐ Very helpful
- 2☐ A little helpful
- 3☐ Not helpful or harmful
- 4☐ A little harmful
- 5☐ Very harmful

71. All things considered, how satisfied are you with your health plan for counseling or treatment?

1☐ Completely satisfied
2☐ Very satisfied
3☐ Somewhat satisfied
4☐ Neither satisfied nor dissatisfied
5☐ Somewhat dissatisfied
6☐ Very dissatisfied
7☐ Completely dissatisfied

72. Do you intend to switch to a different health plan for counseling or treatment when you next have an opportunity?

1☐ Definitely yes
2☐ Probably yes
3☐ Probably not
4☐ Definitely not

73. As far as you know, will your health plan for counseling or treatment be offered next year?

1☐ Yes
2☐ No

74. Overali, how confident are you that your current health plan for counseling or treatment is the best for you?

1☐ Extremely confident
2☐ Very confident
3☐ Somewhat confident
4☐ A little confident
5☐ Not at all confident

REASONS FOR COUNSELING OR TREATMENT

75. In the last 12 months, was any of your counseling or treatment for mental or emotional illness?

1☐ Yes
2☐ No

76. In the last 12 months, was any of your counseling or treatment for personal or family problems?

1☐ Yes
2☐ No

77. In the last 12 months, was any of your counseling or treatment for help with alcohol use?

1☐ Yes
2☐ No

78. In the last 12 months, was any of your counseling or treatment for help with drug use?

1☐ Yes
2☐ No

79. In general, how would you rate your overall mental health now?

1☐ Excellent
2☐ Very good
3☐ Good
4☐ Fair
5☐ Poor

80. In general, how would you rate your recovery now?

1☐ Excellent
2☐ Very good
3☐ Good
4☐ Fair
5☐ Poor

About You

81. In general, how would you rate <u>your overall health</u> now?

1☐ Excellent
2☐ Very good
3☐ Good
4☐ Fair
5☐ Poor

82. What is your age now?

1☐ 18 to 24
2☐ 25 to 34
3☐ 35 to 44
4☐ 45 to 54
5☐ 55 to 64
6☐ 65 to 74
7☐ 75 or Older

83. Are you male or female?

1☐ Male
2☐ Female

84. What is the highest grade or level of school that you have <u>completed</u>?

1☐ 8th grade or less
2☐ Some high school, but did not graduate
3☐ High school graduate or GED
4☐ Some college or 2-year degree
5☐ 4-year college graduate
6☐ More than 4-year college degree

85. Are you of Hispanic or Latino origin or descent?

1☐ Hispanic or Latino
2☐ Not Hispanic or Latino

86. What is your race? Please mark one or more.

1☐ White
2☐ Black or African-American
3☐ Asian
4☐ Native Hawaiian or other Pacific Islander
5☐ American Indian or Alaska Native
8☐ Other (please print)

_____

87. Did someone help you complete this survey?

1☐ Yes ∅ **If Yes, Go to Question 88**
2☐ No ∅ **If No, Please return the survey in the postage-paid envelope**

88. How did that person help you? Check all that apply.

1☐ Read the questions to me
2☐ Wrote down the answers I gave
3☐ Answered the questions for me
4☐ Translated the questions into my language
8☐ Helped in some other way (please print)

_____

* ***Optional: Insert additional demographic questions here.***

THANK YOU!

Please return this survey in the postage-paid envelope to:

Vendor Name and Address

No presentation or handout materials were received from Jeanne Mcgee prior to the meeting for inclusion in the handout binder.

National CAHPS Benchmarking Database (NCBD) User Group
Thursday, March 8th
3:30 p.m.

What is the NCBD?

The National CAHPS Benchmarking Database (NCBD) is the national repository for CAHPS® data. The primary purpose of the NCBD is to facilitate comparisons of CAHPS results among various types of survey sponsors, including Medicaid agencies, public and private employers, Medicare and individual health plans. These comparisons are intended to provide both purchasers and health plans with benchmarking information useful for evaluating and improving performance as measured by the CAHPS survey. The NCBD also offers an important source of primary data for conducting specialized research that will enable improvements in future survey design and a better understanding of health plan and enrollee characteristics that influence performance.

Who Participates in the NCBD?

All sponsors of CAHPS surveys that are administered independently according to CAHPS specifications are invited to participate in the NCBD. Survey sponsors include public and private purchasers (employers, state Medicaid agencies, Medicare) and individual health plans. Survey sponsors participate in the NCBD simply by submitting their CAHPS survey results according to specified guidelines. In return, participating sponsors receive a customized report that compares their own results to appropriate benchmarks derived from the NCBD. Comparisons include national averages by population sector and the 90th percentile score for CAHPS results.

What Will be Covered in the NCBD Users Session (March 8th at 3:30 p.m.)?

During previous evaluation activities, sponsors have requested more opportunities to learn from their peers regarding use of NCBD data. In response, we've planned an interactive discussion of barriers encountered when using NCBD data and their resulting solutions. Our intention is that the discussion will cover real issues that sponsors have encountered within their own projects; similar to those discussed in the Sponsor Spotlight feature within the *NCBD News* (see attached for the December issue). Participants will be able to share their own experience as well as learn from other's experience. We invite anyone who is interested in learning more about the issues involved in using NCBD data to attend this session.

Where Can I Get More Detailed Information About NCBD?

Further information about the NCBD is available through the NCBD Web page at: http://ncbd.cahps.org/.

NCQA

HEDIS/CAHPS® 2.0H

A Powerful Tool For Both
Standards and HEDIS

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Overview

- MCO Accreditation
  - Scoring CAHPS® in accreditation
  - Using CAHPS® to demonstrate improvement
  - Where can I get summary results for benchmarks and thresholds
- PPO Accreditation
- Quality profile studies

MCO Accreditation - Potential Impact of Consumer Survey

Activity	Standard/ Measure	Points tw. Total score
Availability: analyze and act	QI 4	2.0
Access: analyze and act	QI 5	2.9
Member satisfaction analyze & act	QI 6	3.9
UM satisfaction members: monitor and act	UM 8	1.3
Achieve improvements in service	QI 12	2.6
Achieve good results	10 Survey Measure	12.5
Total impact on score		25.2

Scoring

How NCQA scores
HEDIS and CAHPS® 2.0H for
Accreditation 2000

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Scoring for Accreditation 2000

- HEDIS® performance still worth 25%
- Benchmarks and thresholds used for scoring are those from 1999 except for Customer Service

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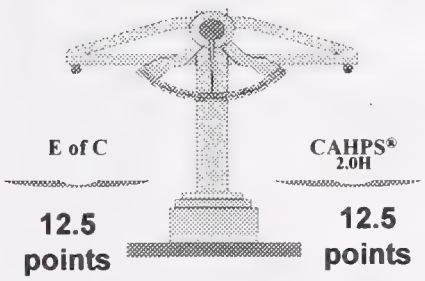
Scoring HEDIS Results:



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Scoring With CAHPS® 2.0H

Each composite or rating's mean are assigned values between 1 and 3 and only national percentiles are used when scoring

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Scoring Scale

HEDIS/CAHPS® 2.0H Results	Scoring Scale Based on Responses	
Getting Needed Care (4 questions)	A big problem	= 1
	A small problem	= 2
	Not a problem	= 3
Customer Service (3 questions)		
Getting Care Quickly (4 questions)	Never or Sometimes	= 1
	Usually	= 2
How Well Docs Comm (4 quest)	Always	= 3
Helpful Staff (2 questions)		
Claims Processing (2 questions)		
Rating of All Health Care	0,1,2,3,4,5,6	= 1
Rating of Health Plan	7,8	= 2
Rating of Personal Doctor	9,10	= 3
Rating of Specialist		

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Scoring With CAHPS® 2.0H

- Adjustment factors:
  - Four ratings means add .05
  - Claims processing and customer Service add .05
- Adjustment factors:
  - Other four composites add .07
- Composites or ratings are not used if the plan has less than 100 respondents to the questions

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Scoring EoC or CAHPS® 2.0H

Results of All 10 Measures Available:

≥ 90th percentile benchmark nationally...1.25 points

Between the 75th and 89th percentile.....1.10 points

Between 50th and 74th percentile.....0.85 points

Between 25th and 49th percentile.....0.50 points

<25th percentile.....0.25 points

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So how does this work?

- EoC measures with denominator < 30 = NA
- CAHPS®2.0H questions with denominator < 100 = NA
- Can have up to 4 NAs for CAHPS® 2.0H, but total number of NAs can not exceed 6

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Scoring EoC or CAHPS® 2.0H

Results Only 8 Measures Available:

≥ 90th percentile benchmark nationally...1.56 points

Between the 75th and 89th percentile ....1.38 points

Between 50th and 74th percentile.....1.06 points

Between 25th and 49th percentile.....0.63 points

<25th percentile.....0.31 points

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What if I have more than the allowed number of NAs?

- If an MCO has > 4 NAs for EoC or CAHPS® 2.0H or more than 6 total
  - Scored based on their standards score only
  - Highest possible accreditation is commendable

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"D SCORE USED IN THIS CASE can only achieve "commendable" status

More Information

- "Guidelines for Calculating HEDIS® 2000 Survey Results" document available on web site
- Pages 16-23 and Appendix 2 in MCO Surveyor Guidelines

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Using consumer experience data to demonstrate improvement

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CAHPS® 2.0H Survey

- Four Versions in
  - Adult Commercial
  - Adult Medicaid
  - Child Commercial
  - Child Medicaid
- Medicare CAHPS

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CAHPS® 2.0H Questions - Adult Commercial

- **Access** - Q6, Q10, Q17, Q18, Q20, Q21, Q25, Q26
- **Service** - Q15, Q24, Q27, Q28, Q29, Q30, Q31, Q32, Q41, Q44, Q46

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Supplemental Questions - Guidelines

- Questions are as specific as possible
- Response options allow for opting out
- Minimize wordiness, complexity and technical jargon
- Response options match the question wording
- Wording consistent with CAHPS® 2.0H
- Do not jeopardize confidentiality
- NOT marketing oriented

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Access: Information for QI

- How long did you wait for a routine app't.?
- How long did you wait for an app't. for illness or injury?
- How often was it as soon as you wanted?

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Claims Processing: Information for Quality Improvement

How often were claims handled:

- In a reasonable time?
- Correctly?
- How often did the health plan make it clear how much you would have to pay?

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QI 4:Standards for PCP and SCP Availability

Use results from CAHPS®2.0H, question 6 and 10 (commercial), in addition to analysis of PCP/SCP availability by geographic area

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QI 5: Accessibility of Services

Use results from CAHPS®2.0H questions 17, 18, 20, and 21 (commercially insured) to measure against MCO's accessibility standards

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QI 6

Member Satisfaction (QI 6): analysis of CAHPS®2.0H required

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QI 12: Meaningful Improvement

- Rates must show improvement
- Must meet other specifications such as timely and strong interventions
- Don't need statistical significance

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UM 8: Satisfaction with UM Process

- Use results from CAHPS®2.0H questions 10, 24, and 25 (commercially insured)
- Must assess practitioner satisfaction using another method

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Identifying Opportunities

- Composite or rating questions at < 90th percentile
- Changes in percentile rankings
- Use of supplemental questions
- Not all service studies arise from CAHPS® data

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Data at the 50, 75, 90th Percentile

- Is there opportunity for improvement?
- How much more will it take to improve a score in this percentile?
- Should I focus my resources elsewhere?

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Using the Survey to Show Improvement: An Example

- UM questions: formerly 9 a, b, c, now the "Getting Needed Care" composite
- Started lower than other plans; set goal of 90 percent reporting no problem for all three questions
- Made major changes in referral system
- Second year: 90 percent on two of three

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Using the Survey to Show Improvement: Impact

- Member satisfaction: QI 6 met; complaint rate lowered
- UM satisfaction for members: UM 8 met
- Improvement as a result of QI: 25% of QI 12 met
- Getting Needed Care: went from 50th percentile to 90th, approximately

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50 → 90 percentile

PPO Accreditation

- Submitting your CAHPS 2.0H results gets you 5 accreditation points
- CAHPS Instrument Panel is working to make future versions of CAHPS more applicable to PPOs
- Eventually PPOs will be scored on CAHPS similar to MCOs

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Go to NCQA site and obtain standards for PPO Accreditation / programs / report cards, o

Where can I get
summary results,
benchmarks,
and thresholds?

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Accreditation Benchmarks and Thresholds

- Six composites
- Four ratings questions
- National results only
- Means
- 90th, 75th, 50th and 25th percentiles from CAHPS 2.0H 1999

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2000 CAHPS®2.0H Data

- 508 Adult commercial submissions
- 84 Child commercial submissions
- Summary and member level files
- 98 Medicaid adult
- 23 Medicaid Child submissions

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2000 State of Managed Care

- Global proportion top box National Average
- DHHS regional averages
- 90th percentile
- 10th percentile

On-line Summary Tables

- Programs/ HEDIS and CAHPS/ 2000 HEDIS Summary Tables
  - –Adult Mean Summary Statistics
  - –Adult Global Proportions
  - –Child Mean Summary Statistics
  - –Child Global Proportions

NCQA's Health Plan Report Card

- Access and service category
  - – Includes accreditation standards, HEDIS and CAHPS®2.0H measures
  - – Plans get from 0 to 4 stars
  - – Based on scoring cut-offs
  - – Commercial, Medicare and Medicaid

State Report Cards

- Composites and ratings questions and individual questions if asked
- Global proportions or rollup-rates when displaying graphically
- Means when scoring plans as average, above, and below

Benchmarks Tailored to Your Needs

With the member level files we can provide benchmarks for selected subgroups of plans and by:

- Health status
- Smokers
- Age
- Gender
- Race
- Education
- Responses to a particular question

CAHPS® 2 .0H Where to Learn More

- www.ncqa.org/hedis /certsurv.html
- HEDIS/CAHPS 2.0®H Survey Vendor list
- Coding Rules for HEDIS/CAHPS®2.0H Results
- Frequently Asked Questions on website

QUALITY PROFILES™: A Practical Guide to QI

Thirty-eight case studies

NCQA Accredited health plans

Broad range of plan types

Step-by-step approach to QI

Successful results

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Quality Profile #33

Member Satisfaction

Working with Provider Groups to Improve Service

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The Plan At a Glance

- Enrollment: 200,000 - 400,000
- Enrollment by product line:
  HMO: 83% Medicare 17%
- Market type: mixed
- Market environment: 17.8 % managed care
- Relevant fact: Utilization management is delegated to medical groups and IPAs.

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Quality Profiles #33
Member Satisfaction

- Problem: A major provider group with widespread member dissatisfaction with referral processes, appointment wait times, and provider communication
- Selected Measures:
  - complaint volume as a % of total plan complaints
  - member satisfaction rates

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Quality Profiles #33

- **Interventions**
  - subcontract referral management
  - customer service training for clinical staff
  - reorganization of executive and support staff

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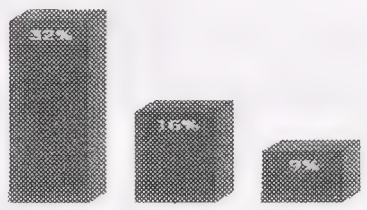
Quality Profiles #33 Evaluation



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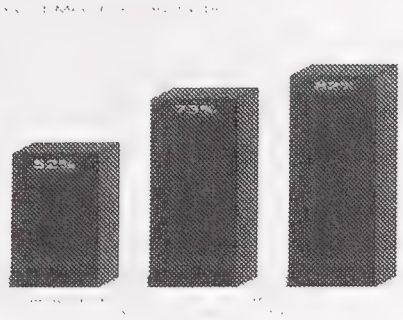
Quality Profiles #33 Evaluation



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Quality Profiles #33 Quality Lesson

Efforts to produce meaningful improvement in service <u>require leadership.</u>

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Quality Profile #34

Primary Care
Appointment Access
Reengineering the Appointment Process

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The Plan At a Glance

- Enrollment: ***200,000 - 400,000***
- Enrollment by product line:
  HMO: 80% Medicare: 11% Medicaid: 8%
- Market type: ***mixed***
- Market environment: **33.3 *% managed care***
- Relevant fact: **This plan is predominantly a group-model HMO.**

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Quality Profiles #34
Reengineering the Appointment Process

- **Problem: Enrollment dropped by 5% and one third of disenrollees sited dissatisfaction with primary care appointment access**
- **Selected Measures:**
  - rate of satisfaction with days to wait for an appointment
  - routine appointment wait time
  - urgent appointment wait time

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Quality Profiles #34
Reengineering the Appointment Process

- **Interventions**
  - Identified plan's triage system as the most significant obstacle
    - Triage upon patient request, no longer mandatory
    - Simplified appointment system codes: "same-day"
    - Implement "same-day" appointment policy

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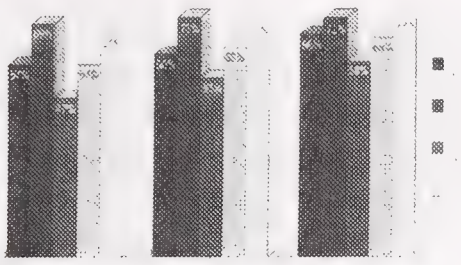
Quality Profiles #34
Reengineering the Appointment Process



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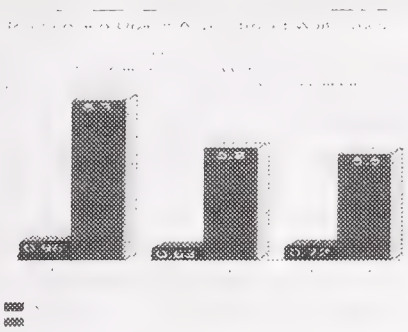
Quality Profiles #34
Reengineering the Appointment Process



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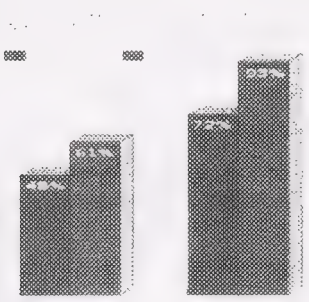
Quality Profiles #34
Reengineering the Appointment Process



NCQA

Measuring the Quality of America's Health Care

Quality Profiles #34 Quality Lesson

Adopting *proven* operations management techniques from other industries can help plans use their limited resources *efficiently.*

NCQA
Measuring the Quality of America's Health Care

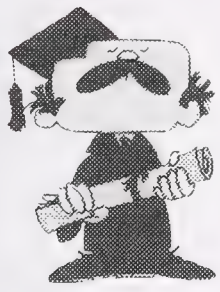
Quality Profiles #34 Quality Lesson

Shifting to a patient-centered system, rather than a system designed to meet staff needs was the *critical first step.*

Physician buy-in and participation in the initiative was *crucial.*

NCQA
Measuring the Quality of America's Health Care

Conclusions



- Use of CAHPS®2.0H survey finds low-hanging fruit
- Comparative data highlights problems and possibilities
- QI leads to success on standards and HEDIS®

NCQA
Measuring the Quality of America's Health Care

National CAHPS User Group Meeting

URAC Accreditation Requirements

Liza Greenberg, RN, MPH
URAC Vice President of Research and Quality Initiatives

March 9, 2001

URAC Accreditation Philosophy

- Modular standards for accountability of operating units within health care organizations
- Approach to accreditation is educational and consultative
- Added value: workshops, conferences and publications
- Consensus driven-standards development

About URAC

- Founded in 1990 as private, non-profit
- Originally focused on utilization review accreditation
- Broad based Board of Directors
- Currently 10 accreditation programs
- Modular approach

URAC Accreditation Programs

10 Modular Programs

- Health Plan (HMO) and Health Network (PPO)
- Case Management
- Health Utilization Management and Work Comp UM
- External Review Organization
- Practitioner Credentialing
- Workers Comp and Specialty Network
- Health Call Center
- CVO

URAC 4

What is the Purpose of Accreditation?

- An objective evaluation of a program's ability to deliver high quality services
- Promote quality improvement
- Meaningful to:
  - Consumers/Patients
  - Employers/Purchasers
  - Providers
  - Regulators
  - Other MCOs

URAC 5

URAC Standards Development Process

- Multi-disciplinary committee process
- "Shalls" and "shoulds" (evolving to scoring system)
- Public input through forums and public comment
- Beta-testing
- Final revisions
- Board approval

URAC 6

Phases of the Accreditation Process

- Applicant self-assessment against standards
- Submission of application
- Desk-top review and request for additional info
- Site visit
- Accreditation decision

URAC 7

Categories Found In All Standards

Organizational Structure
Staff Qualifications and Training
Quality Management and Improvement
Oversight
Information Management
Consumer and Provider Protections

URAC 8

Health Plan/Health Network Standards

Network Management
Credentialing
Quality Management
Member Protection
PPO Standards: Optional Utilization Management Module

URAC 9

More on QM Requirements - HMOs

HMOs:

- Required to carry out 3 QM projects, at least two of which must be clinical
- Projects must be in areas of high need, where improvement can be demonstrated
- CAHPS is encouraged as a QM tool
- Data collected through methods such as:
  - member and provider surveys
  - medical record reviews
  - utilization studies
  - member complaint and grievance data
  - internal performance measurement

Compliance with QM Standards:

- Organizations applying for Health Plan Accreditation for the first time must have in place the necessary policies, structures, and processes to conduct quality management in accordance with these standards. In addition the organization must have implemented its quality management program at least twelve months prior to the URAC accreditation site visit.
- Organizations applying for reaccreditation must have conducted quality management in accordance with these standards for at least two years.

More on QM Requirements - PPOs

- Required to carry out at least 2 QM projects, one of which *should* be clinical
- Projects must be in areas of high need, where improvement can be demonstrated
- CAHPS is encouraged as a QM tool

Accreditation Reviewers

- Reviews are carried out by URAC staff and consultant physicians or attorneys
- Applicant has a single point of contact from from desktop review through accreditation decision
- Applications are assigned to an accreditation reviewer by specialty (UM, CM, HMO, PPO)
- Reaccreditation applicants assigned to previous accreditation reviewer
- Inter-rater reliability studies are conducted to ensure staff and consultant consistency

URAC 13

Contents of The Application

Accreditation manual and interpretive guide specify appropriate documentation for each URAC standard

Examples of documentation:

- Policies/procedures (confidentiality)
- Job descriptions
- Quality measurement/improvement tools
- Description of criteria development
- Committee minutes and notes
- Corporate information

URAC 14

Desktop Review

- Applicant's documentation is reviewed to determine whether standards are met on paper
- Additional information requested from company if there is insufficient documentation of compliance with standards
- Company has 30 days to submit additional information

URAC 15

On-site Review

Goal:

- To verify information submitted in application documentation
- 1-3 day visit with 1-3 staff and consultants
- On site activities:
  - Interviews with key leadership and line staff
  - record audits
  - observations

URAC 16

Application Approval Process

Accreditation Committee
Executive Committee

Appeals permitted by applicants not satisfied with the accreditation decision

URAC 17

Accreditation Levels

Full:

Company has fully implemented standards according the intent

Conditional with follow-up onsite review:

1) Company has policies in place to comply with standards, but not fully implemented

2) Start-up organizations

URAC 18

Other Accreditation Decisions

Corrective Action with follow-up onsite review:
Company must make major changes in several areas to comply with standards (typically 6 months)

Denial:
Company determined to be not able to come into compliance within 6 months.

URAC 19

Reaccreditation/Interim Activities

- Reaccreditation required every two years
- Credentialing progress reports for phase-in networks
- 6-month follow up visit for conditional accreditations
- Complaint investigation

URAC 20

Future Directions

- Continue to develop modular approach consistent with trends in health care delivery system
- Exploring interface between UM, DM and CM
- New standards for health web sites, claims payment programs
- Examining limited performance measures for HMOs and PPOs
- Patient safety

URAC 21

For More Information

URAC
1275 K Street NW
Suite 1100
Washington, D.C. 20005
(202) 216-9010 fax (202) 216-9006
www.urac.org

URAC 22

No presentation or handout materials were received from Liz Goldstein prior to the meeting for inclusion in the handout binder.

Medicare CAHPS

Liz Goldstein
Amy Heller
Ted Sekscenski

CAHPS Users Conference
March 2001
Las Vegas, Nevada

Medicare CAHPS Surveys

- ✓Managed Care CAHPS
- ✓Managed Care Voluntary Disenrollee CAHPS
- ✓Medicare Fee-For Service CAHPS

Purposes

- ✓Consumer information
  - This year will be providing beneficiaries with managed care and fee-for-service comparison.
- ✓HCFA monitoring of health plan performance
- ✓Quality improvement
  - This year working towards linking CAHPS measures with clinical measures and outcomes.

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Status of Managed Care CAHPS

- ✓Conducted yearly since Fall 1998
- ✓Reported in *Medicare & You* since 1999
- ✓Reported on Medicare.gov website
- ✓Most recent round conducted in Fall 2000
  - Redesign of sampling units

Redesign of Sampling Units for Managed Care CAHPS: Purpose

- ✓To develop a more locally-based sampling unit
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- ✓To develop a more systematic way of defining market areas

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- ✓225,156 enrollees
- ✓257 health plans
- ✓381 sampling units

Managed Care - Response Rate

- ✓82.7 percent
  - – wave 1 (mailing): 56 percent
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- ✓Sub-groups of interest include: African-Americans, the disabled, Hispanic/Latinos and the elderly with special health care needs.

Sub-Group Analysis

- ✓Analyzing the experiences of each sub-group for comparative purposes.

- ✓This information will be shared with the health plans, to assist in creating quality improvement activities, to better target the health needs of each identified sub-group.

Managed Care CAHPS® and Quality Improvement

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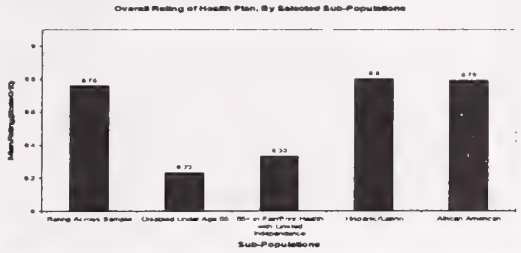
This table demonstrates that the various sub-groups rate their **overall experiences with their health plans** very differently. Hispanic/ Latino members are the most satisfied with their health plans while the disabled under 65 are the least satisfied



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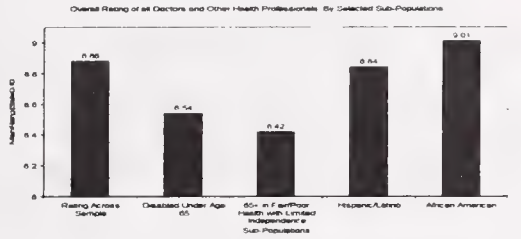

- ✓ This table demonstrated the **differences in quality ratings of doctors and nurses by the various sub-groups** African-Americans rate the quality of their doctor and nurse more favorably than any other group Those over 65 years old and in poor/fair health rate the quality of their doctor and nurse least favorably.

Why do we have these results ?

Subgroup Findings

- ✓ Analysis of MMC CAHPS from previous years revealed both positive and negative responses including:

- ✓ POSITVE response
  - Hispanics, non-whites and Medicare beneficiaries with less than a ninth grade education report a higher levels of satisfaction with managed care plans than did other Medicare beneficiaries.

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- ✓ Informed Consumer Choice Under BBA
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- ✓ Survey of Reasons for Disenrollment
  - Results to be paired with disenrollment rates
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  - mixed mode of survey administration (i.e., mailed questionnaire with telephone follow-up of non-respondents)
  - quarterly administration with results cumulated for the year/reduces recall, better data quality
  - first administration 5/2000
- ✓ Reporting - pair presentation of disenrollment rates with reasons for disenrollment, 2001

I don't like the term "looking at."

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  - Proportional to the sampling rate used in the Enrollee survey (but no more than 600)

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Preliminary results - please do not cite or quote

Fee-for-Service Survey

Medicare CAHPS™-FFS

- ✓Required by BBA 1997
- ✓Consumer Satisfaction & Experience for 33 million beneficiaries in Original FFS Medicare Program
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CAHPS™-FFS Survey Development Goals

- Develop CAHPS questionnaire for measuring beneficiaries' satisfaction and experience with original Medicare FFS program
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- Develop and test alternative methods of case-mix adjustment

MFFS CAHPS™ Field Test Results

- Instruments performed well -- i.e one can obtain valid & reliable estimates of consumer satisfaction in Original Medicare FFS Program
- Internal consistency reliability was estimated for all MFFS composite scores, and state-level reliability was estimated for both composite and single-item scores.

Field Test Results -- continued

- Six-month recall period performed better than 12-month recall for most MFFS beneficiaries, e.g. yielded higher overall response rates

- Age & health status were significantly related to assessments of overall health care and will be included in MFFS case-mix adjustment model

MFFS Field Test - Data Results

Supplemental Insurance

- 3/4 of respondents had private supplemental insurance.
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- 6 in 10 had supplemental insurance for prescription medicines.

- Supplemental prescriptive coverage correlated positively with getting needed care & health plan rating

MFFS National Sample Frame

- ✓30+ Million in Original FFS Medicare
- ✓Continually enrolled in MFFS for 6+ mos
- ✓Included both 65+ and under 65 years
- ✓Will exclude institutionalized from sample respondents
- ✓Will analyze "Representative Payee" addressees in sample responses

National CAHPS™-FFS Sample Design

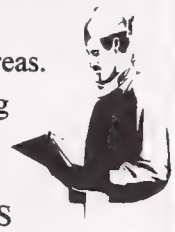
- ✓National Sample size: 168,000 MFFS beneficiaries in all 50 States, the District of Columbia, and Puerto Rico.

2000 MFFS Data Collection

- ✓National sample collected MFFS Data in 275 geographic areas based on States, MSAs, HSAs, & MCSAs
- ✓Reporting units: 300 -600+ beneficiaries

MFFS CAHPS™ National Fall 2000 Preliminary Results

- Obtained 65% response rate nationwide; approaching 75% response in several reporting areas.
- Item responses excellent among virtually all returned questionnaires
- 2000 Survey will support MFFS Composites similar to those from MMC in past 3 years.



Reporting 2000 Survey CAHPS-FFS Measures

- ✓MFFS measures will be reported for each State and for all areas where MMC health plans are available.
- ✓Plan for MFFS data to be on Medicare.gov web-site by Fall 2001.

MFFS CAHPS® & Quality Improvement

- ✓ Flu shot, pneumonia shot & smoking cessation counseling info for all 275 sub-state geographic areas in MFFS CAHPS Survey
- ✓MFFS-CAHPS info also linkable to FFS Claims data at beneficiary level.

Medicare CAHPS

Liz Goldstein
Amy Heller
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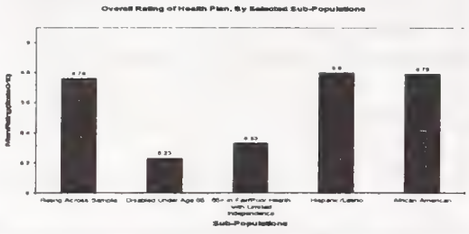

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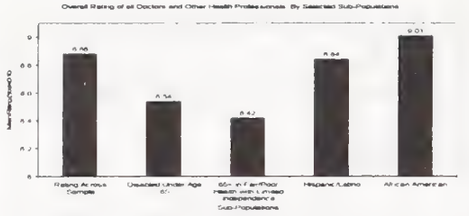
Overall Rating of all Doctors and Other Health Professionals, By Selected Sub-Populations
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Rating Across Sample
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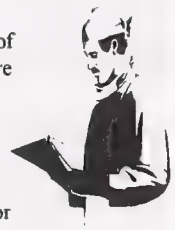

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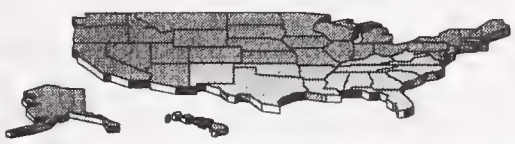
- ✓Will analyze "Representative Payee" addressees in sample responses

National CAHPS™-FFS Sample Design

- ✓National Sample size: 168,000 MFFS beneficiaries in all 50 States, the District of Columbia, and Puerto Rico.



2000 MFFS Data Collection

- ✓National sample collected MFFS Data in 275 geographic areas based on States, MSAs, HSAs, & MCSAs
- ✓Reporting units: 300 -600+ beneficiaries

MFFS CAHPS™ National Fall 2000 Preliminary Results

- Obtained 65% response rate nationwide; approaching 75% response in several reporting areas.
- Item responses excellent among virtually all returned questionnaires
- 2000 Survey will support MFFS Composites similar to those from MMC in past 3 years.

Reporting 2000 Survey CAHPS-FFS Measures

✓MFFS measures will be reported for each State and for all areas where MMC health plans are available.

✓Plan for MFFS data to be on Medicare.gov web-site by Fall 2001.

MFFS CAHPS® & Quality Improvement

✓ Flu shot, pneumonia shot & smoking cessation counseling info for all 275 sub-state geographic areas in MFFS CAHPS Survey

✓MFFS-CAHPS info also linkable to FFS Claims data at beneficiary level.

No presentation or handout materials were received from Ron Hays prior to the meeting for inclusion in the handout binder.

No presentation or handout materials were received from Loel Solomon prior to the meeting for inclusion in the handout binder.

Developing Shorter CAHPS Reports for Medicaid Members

Lessons Learned from Report Testing in Massachusetts and Washington State

Fiona Smith, MPH
The Picker Institute

CAHPS User Group Meeting
March 9, 2001

Acknowledgements

- Massachusetts Department of Medical Assistance
- Washington State Medical Assistance Administration
- CAHPS Reports Team

Background

- CAHPS reports templates developed and tested with commercial population
- Initial report templates tested with
  - State employees in Oregon
  - Medicare members in Kansas
  - Medicaid members in Florida and New Jersey
  - Employees in Washington State

Background, con't

Findings from Initial Rounds of Testing

- Report seen as too long and complex, yet consumers also wanted more specific information about doctors, locations, etc
- Consumers don't understand stars and the relationship between stars and bars
- Many consumers lack necessary background information on how health care system works

Testing Shorter CAHPS Reports in MA and WA

- Goal
  - To test shorter versions of the standard CAHPS report with Medicaid members
- Methods
  - Focus groups and interviews with 46 Medicaid members in Massachusetts
  - Focus groups with 19 Medicaid members in Washington State

Results

- Simple reports are preferred
  - But page length is not the only concern
  - Difficulty of integrating other information about plan choices without causing information overload
- The importance of the message
  - To build expectations
  - To explain steps in decision-making process
  - To encourage active selection

CAHPS Through Coalitions

Results, con't

- Inconsistent comprehension of data displays
  - More errors in MA than WA
  - Discrepancy between reported ease of use and actual comprehension
- Problems with numerical concepts
  - State average
  - Relationship between chart and bar graphs

Challenges

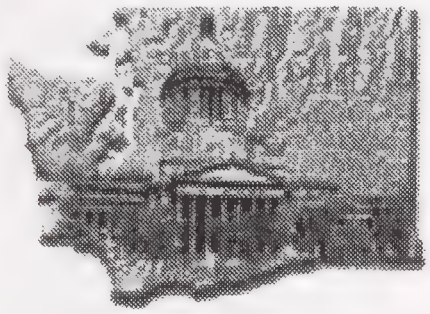
- The current health care environment
  - Managed care plans exiting markets
  - Differing service areas
  - Negative implications of displaying plans that perform below average in a Medicaid report
- The audience
  - Diversity of Medicaid members in terms of health status, education, and information needs
  - Short length of enrollment for some can decrease importance of health plan selection

More Challenges

- CAHPS information is just one of many enrollment materials
- Print materials are not sufficient for all
- Expense of a multi-media communication approach

Next Steps

- Testing the effect of report length in Massachusetts field study
- Integrating CAHPS information into enrollment materials
- Developing different reporting mechanisms for different audiences



Washington State Medicaid Program

2001 Enrollment Booklet Improvement Project

Goals of this new project

- Make it easier for clients to understand the Medicaid program and enrollment process
- Increase the percentage of clients who choose a health plan when they enroll (rather than being assigned to a plan)
- Emphasize health plan performance information (help clients choose, make plans more accountable for improvement)

1

Steps in our improvement project

1	2	3	4	5
Start up: the team, the goals, etc.	Set up ways to involve stake-holders throughout the project	Review previous efforts; assess what is needed; plan project evaluation	Create and test mockups with clients; revise and test again	Final product

2

1 Start up in December 2000

- Organize the team
- Funding from the State's *Savings Incentive Account* covers:
  - Assistance from an outside consultant
  - Several rounds of client testing
- Changed our name from "IEFPPR" to "EBIT"

3

2 Involve stakeholders

Who are they (besides clients) **?**

- Obvious stakeholders are health plans, client advocacy / outreach organizations
- Other areas within state government are also stakeholders
  - Sister agency that administers another low-income program
  - Those who will implement the new design

4

Involve stakeholders *(continued)*

Our approach:

- Communication by email
  - Generate the list from flyers distributed at meetings and electronically *(see example)*
  - Use the email list to provide periodic updates and get reactions to mockups
- Meetings (with health plans, outreach organizations)
- Participation on the team (government staff)

5

Involve stakeholders (continued)

The payoff we expect:

- Good ideas at the outset
- Helpful feedback on mockups used in client testing
- More buy-in and better acceptance of the final product
- Easier implementation due to better coordination among government divisions

6

3 Assessment and planning

Previous reports of CAHPS survey results:

- **1997:** 1st CAHPS survey; stakeholder report only (no brochure for clients)
- **1998:** 1st client brochure - a large sheet that folds out, county-specific versions in multiple languages

7

Assessment and planning (continued)

Previous CAHPS reports, continued:

- **1999:** Seven-page client brochure, *not* county specific, included in packet of enrollment materials
- **2000:** Seven-page client brochure, *not* county specific, included in packet of enrollment materials, produced in time for displaced client mailing

8

Assessment and planning (continued)

The plan for 2001:

- **Integrate** CAHPS survey information into the enrollment booklet, along with descriptive plan-specific information
- Remove material about "how to use your health plan" from the enrollment booklet
- Make the enrollment form, instructions, and other information in the booklet easier to understand and use

9

Assessment and planning (continued)

Design and production challenges / constraints:

- **Ideally**, the enrollment booklet will be tailored to geographic areas, showing only the health plans available in that area
  - We know from consumer testing in 1998 that it's very hard for clients to use state-wide CAHPS reports
  - Clients resent seeing information about health plans that are not available in their area
- **But** - producing multiple versions of the booklet is more complex, costly, time consuming

10

Assessment and planning (continued)

Design and production challenges / constraints:

- Several different divisions of state government are involved, and the systems and production issues are complex
  - One group handles *all* forms, including enrollment form in the booklet; other groups handle printing, mailing
  - Savings in one area may mean higher costs in another
- Pre-printing of personalized client information on the enrollment form is very helpful, but it's challenging in terms of design and production

11

Assessment and planning (continued)

How will we measure our success?

- The team discussed evaluation at the beginning of the project
- Many interesting approaches to measuring improvement are too difficult, too complex, or too costly to implement
- *Decision:* do systematic assessment at end of the project, using brief survey to get feedback from stakeholders on the email list and staff who help clients get enrolled

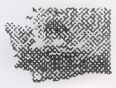
12

4 Client testing, revisions

What will we test?

- Several options are being considered
  - *For example:* A folder with inserts - one sheet for each health plan, in standardized format, giving CAHPS results and other plan-specific information
- Which survey questions to include, and whether/how to aggregate the questions is under review

13



Client testing, revisions (continued)

How will we test the mockups?

- Three rounds of testing with Medicaid clients
  - One-on-one "cognitive interviews" done by an interviewer and note-taker to get the client's reactions to the content and format of the mockup
  - "Usability" testing: Later rounds focus on how easy it is for clients to **use** the revised booklet

14

Client testing, revisions *(continued)*

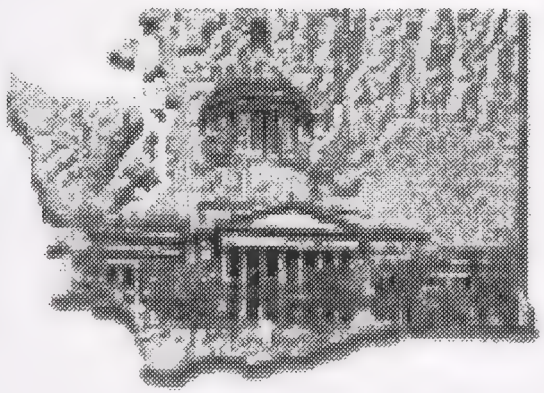
- We will also be seeking feedback from health plans, outreach workers, and other stakeholders about the mockups we are testing with clients
  - Posting mockups to a website
  - Inviting review and comment by email

15

5 The final product

- Revisions to be completed by early summer
- Evaluation to be conducted at the end of the project
  - How well did we succeed at developing a reader-friendly enrollment booklet?
  - How well did our process work for those involved?

16



SoonerCare Plus Report Card 2000-2001

Darendia McCauley, Ph.D.
Director, Quality Assurance

Oklahoma Health Care Authority 1

SoonerCare Plus Report Card

Adobe Acrobat
Document

Oklahoma Health Care Authority 2

Questions & Comments

Thank You.
McCauleD@ohca.state.ok.us
www.ohca.State.Ok.Us
www.ofmq.com

Oklahoma Health Care Authority 3

The _____ *SoonerCare Plus* _____ Health Plan

Welcome...

Thank you for taking the time to review your ***SoonerCare Plus*** report card. This report card provides information about what members thought of their experience with the ***SoonerCare Plus*** health plan.

The report card covers summer 1999 to spring 2000. The survey involved the HMO Medicaid service areas in and around Lawton, Oklahoma City and Tulsa that are included in the ***SoonerCare Plus*** program.

We hope that you will find the report card helpful. If you have any questions, please call the ***SoonerCare*** Helpline listed below.

SoonerCare **Helpline**

1-800-987-7767
or for the hearing impaired, call
1-800-757-5979 (TDD/TTY)

SoonerCare Plus Report Card

Choosing a Health Plan

This booklet explains what ***SoonerCare Plus*** members think about their health plan. We sent a list of questions to members who receive ***SoonerCare Plus*** health care benefits. The questions asked about their experiences in getting health care. Members of the plan answered the questions and described the care they received from their doctors and health plan.

How to Use This Booklet

Step 1

Go to pages 4 through 11 to find what people like you thought about the health plans in which they were enrolled. A worksheet is provided to the right of each graph for you to note how well these plans did. Check either "yes" or "no" if you think this health plan did well on the items that are important to you.

Step 2

Go to page 12 to:

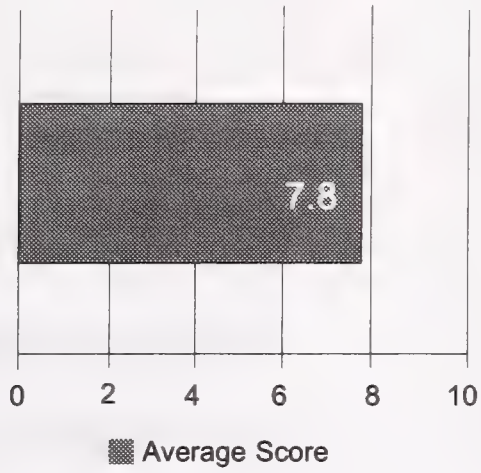
- list the health plans that you checked "yes" for on pages 4 through 11 and
- learn about important questions you should ask about health plans before you make a choice.

CAHPS THROUGH COALITIONS

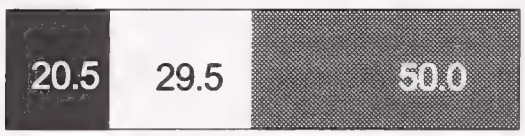
What the Bar Graphs Tell You

The bar graphs on pages 4 through 11 show how people answered the different survey topics. Each health plan has a bar for each survey topic.

The plan's overall rating on a scale of 0 to 10



What the bars divided into three sections tell you



The "Big Problem" answers are always at this end of the bar in black. They are the "least positive" answers.

The "Small Problem" answers are always in the middle in the white box. They are the "in-between" answers.

The "Not a Problem" answers are always at this end of the bar in gray. They are the "best" answers.

The bars on the graphs may not always equal 100 percent due to rounding.

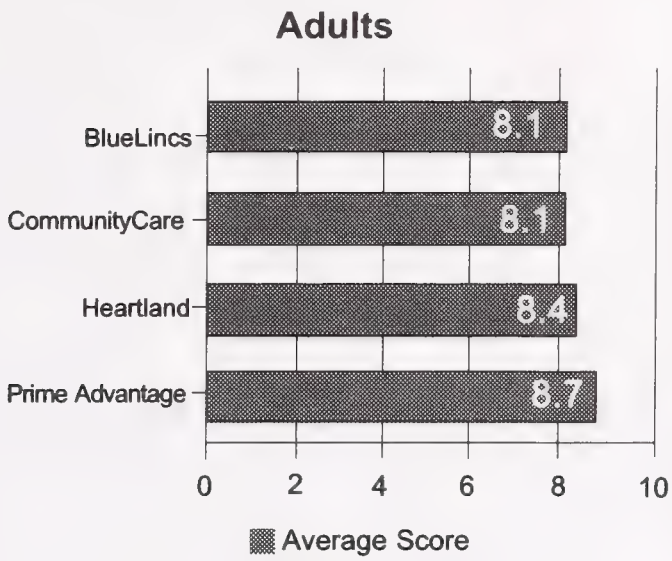
What You Should Look for

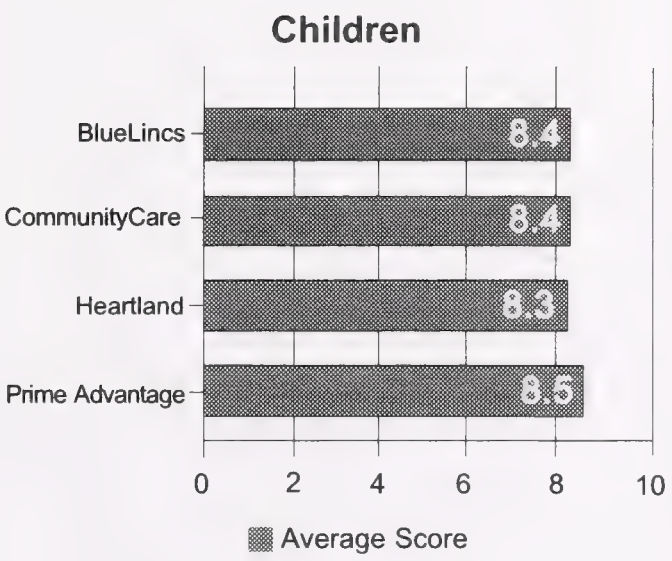
Look for large differences when you compare plans. The bigger the gray section, the more positive the response. Keep in mind that small differences don't mean much.

Overall Rating of Doctor

How would you rate your or your child's doctor now? The survey asked people to use any number on a scale from 0 to 10, with 0 being the worst doctor possible and 10 the best possible.

The graph shows how the people surveyed rated their own or their child's doctor.





YOUR WORKSHEET

Rate the Plan

Did this plan do well?

❑ Yes ❑ No

❑ Yes ❑ No

❑ Yes ❑ No

❑ Yes ❑ No

Did this plan do well?

❑ Yes ❑ No

❑ Yes ❑ No

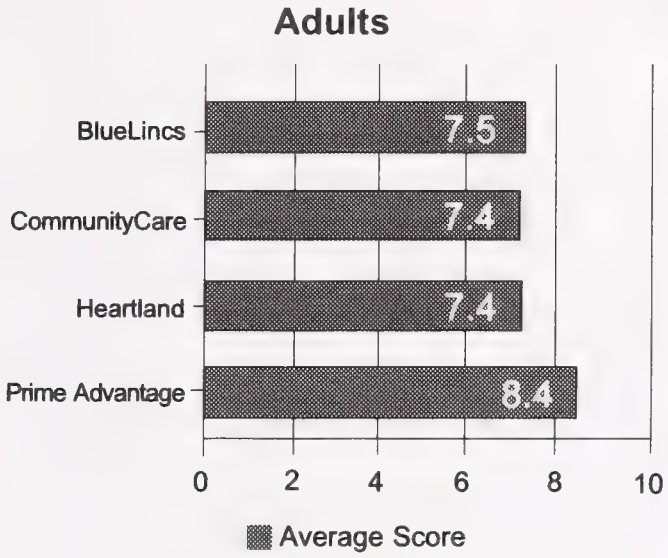
❑ Yes ❑ No

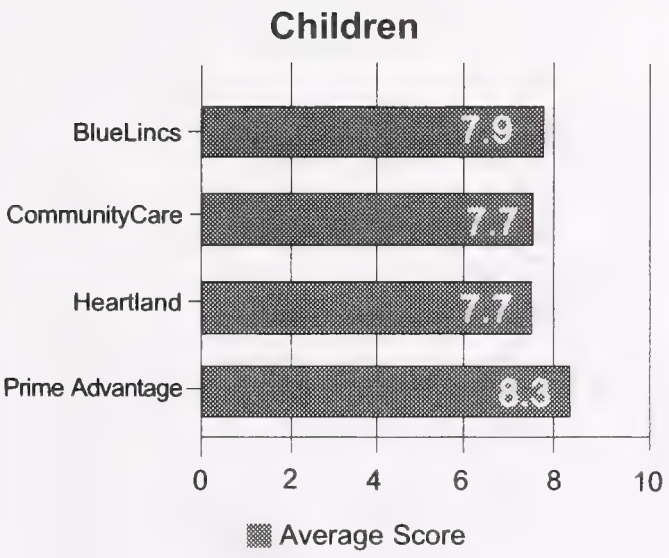
❑ Yes ❑ No

Overall Rating of Health Plan

How would you rate your or your child's health plan now? The survey asked people to use any number on a scale from 0 to 10, with 0 being the worst health plan possible and 10 the best.

The graph shows how the people surveyed rated their own or their child's health plan.





YOUR WORKSHEET

Rate the Plan

Did this plan do well?

❑ Yes ❑ No

❑ Yes ❑ No

❑ Yes ❑ No

❑ Yes ❑ No

Did this plan do well?

❑ Yes ❑ No

❑ Yes ❑ No

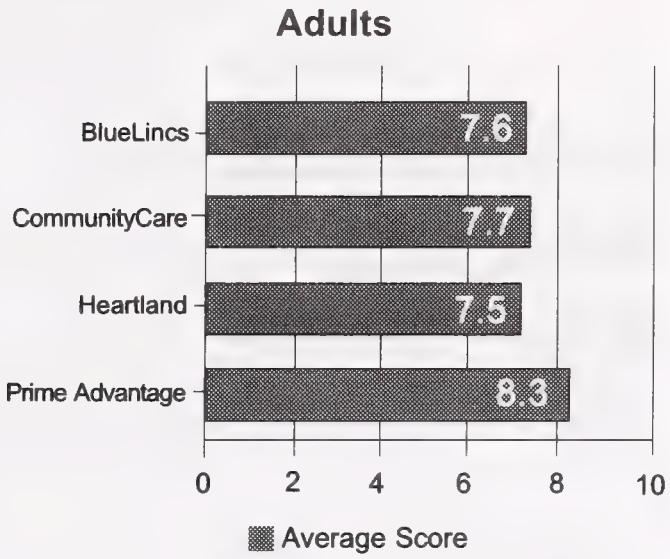
❑ Yes ❑ No

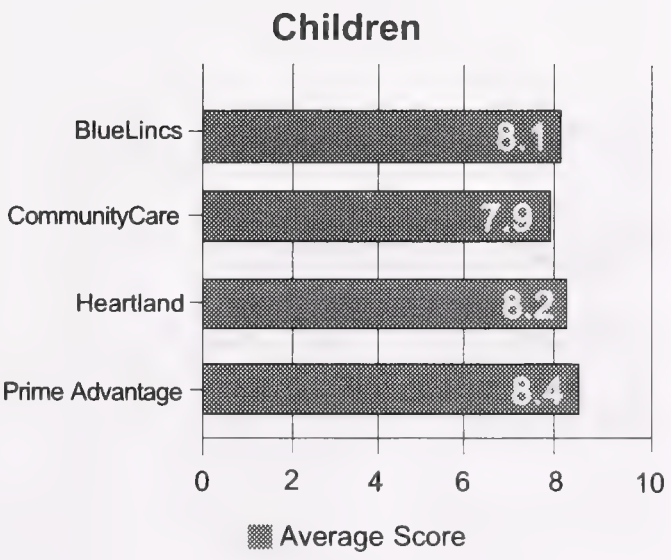
❑ Yes ❑ No

Overall Rating of Health Care

How would you rate all of your or your child's health care? The survey asked people to use any number on a scale from 0 to 10, with 0 being the worst health care possible and 10 the best.

The graph shows how the people surveyed rated their own or their child's health care.





YOUR WORKSHEET

Rate the Plan

Did this plan do well?

❑ Yes ❑ No

❑ Yes ❑ No

❑ Yes ❑ No

❑ Yes ❑ No

Did this plan do well?

❑ Yes ❑ No

❑ Yes ❑ No

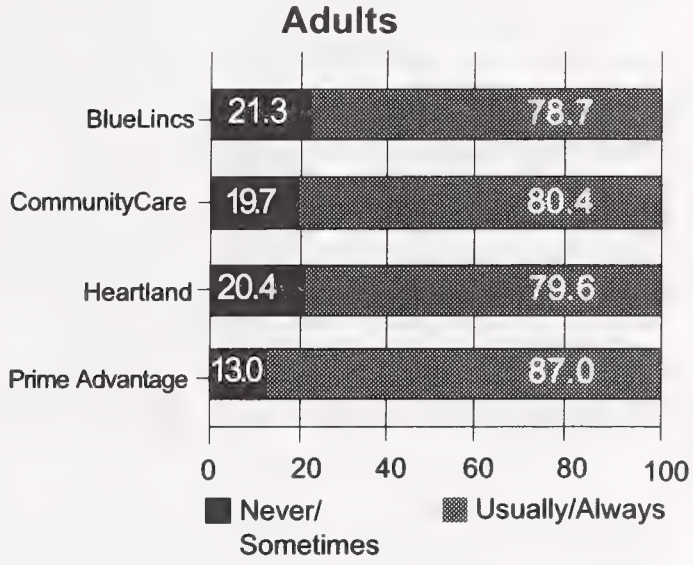
❑ Yes ❑ No

❑ Yes ❑ No

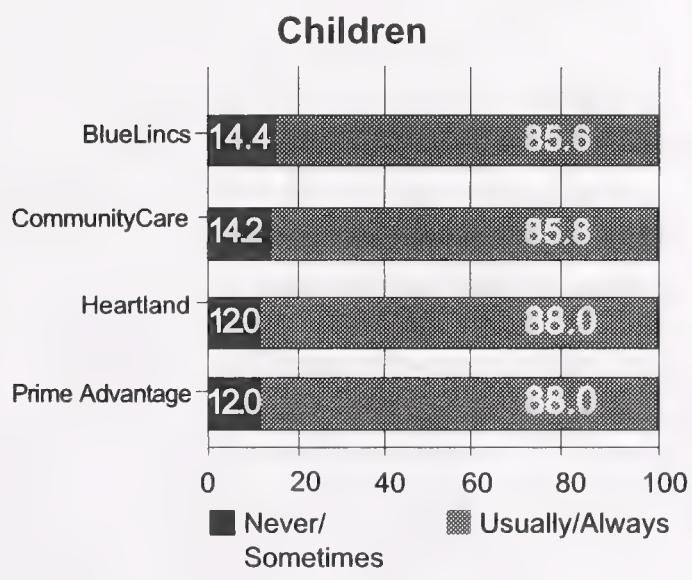
Doctors Communicating Well with Patients

The survey asked people how often their own or their child's doctor or health care professionals:

- Listened carefully to them
- Explained things in a way they or their child could understand
- Showed respect for what they had to say
- Spent enough time with them or their child



Bars may not equal 100 percent due to rounding.



YOUR WORKSHEET

Rate the Plan

Did this plan do well?

❑ Yes ❑ No

❑ Yes ❑ No

❑ Yes ❑ No

❑ Yes ❑ No

Did this plan do well?

❑ Yes ❑ No

❑ Yes ❑ No

❑ Yes ❑ No

❑ Yes ❑ No

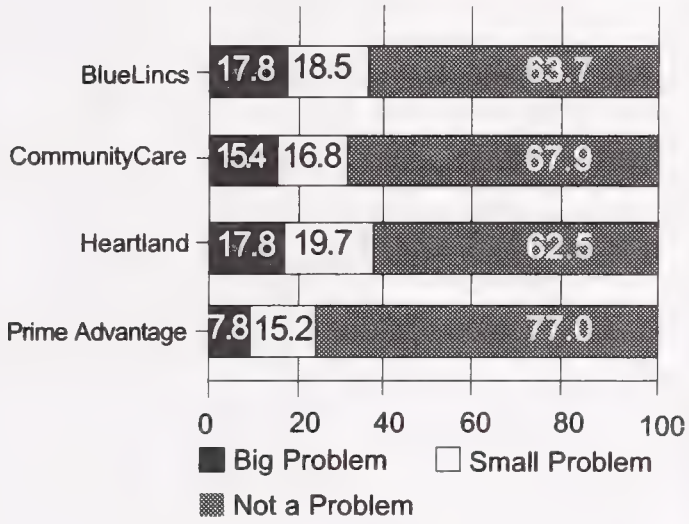
The percentages shown on the bars are the average of answers to the four survey questions listed above.

Getting the Care You Need

The survey asked people how often they or their child:

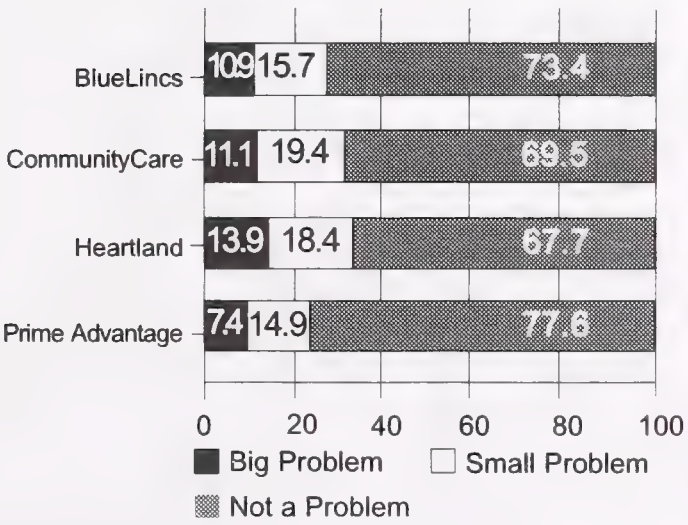
- Got a personal doctor or nurse they were happy with
- Got a referral to a specialist that they or their child needed to see
- Got the care they or their doctor believed necessary
- Had delays in health care while they waited for approval from their or their child's health plan

Adults



Bars may not equal 100 percent due to rounding.

Children



YOUR WORKSHEET

Rate the Plan

Did this plan do well?

❑ Yes ❑ No

❑ Yes ❑ No

❑ Yes ❑ No

❑ Yes ❑ No

Did this plan do well?

❑ Yes ❑ No

❑ Yes ❑ No

❑ Yes ❑ No

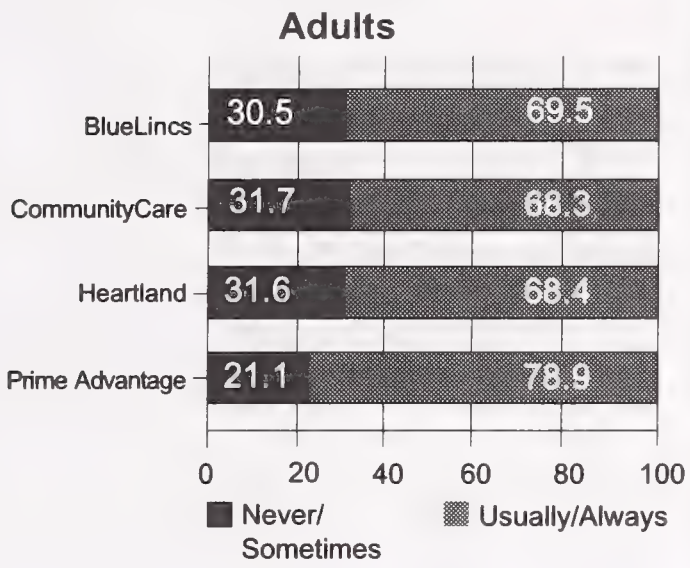
❑ Yes ❑ No

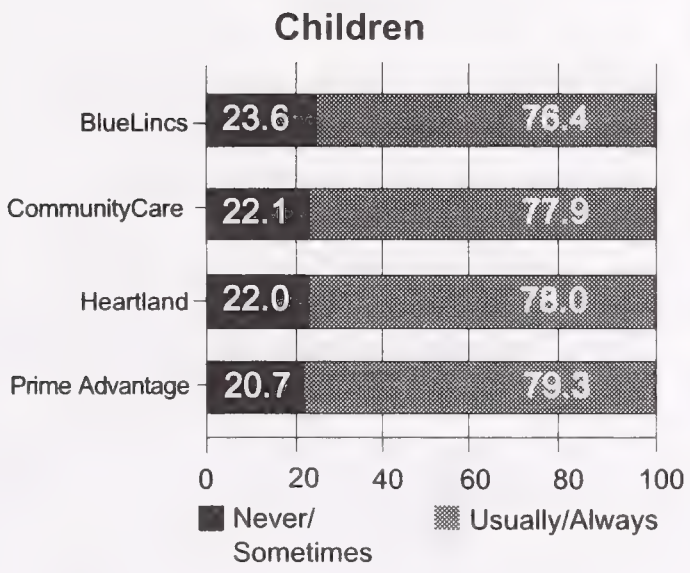
The percentages shown on the bars are the average of answers to the four survey questions listed above.

Getting Care Quickly

The survey asked people how often they or their child:

- Received help or advice when they called during regular office hours
- Had an appointment for regular or routine health care as soon as they wanted
- Received needed care for an illness or injury as soon as they wanted
- Waited in the doctor's office or clinic more than 15 minutes past their appointment time





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❑ Yes ❑ No

❑ Yes ❑ No

❑ Yes ❑ No

Did this plan do well?

❑ Yes ❑ No

❑ Yes ❑ No

❑ Yes ❑ No

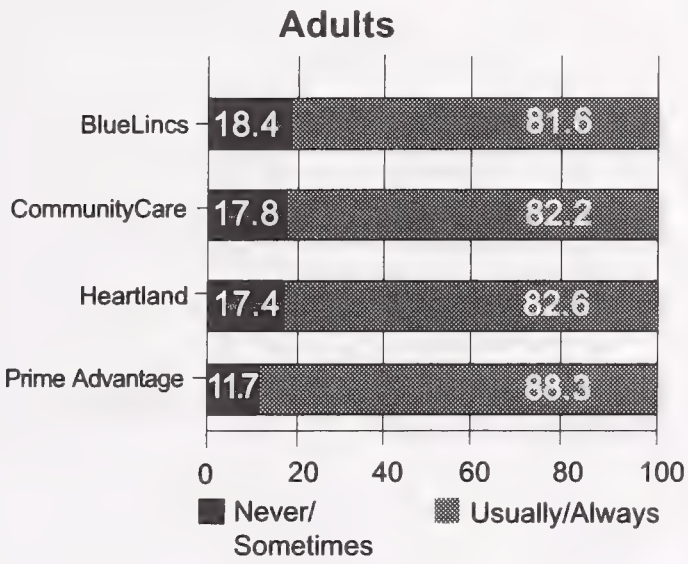
❑ Yes ❑ No

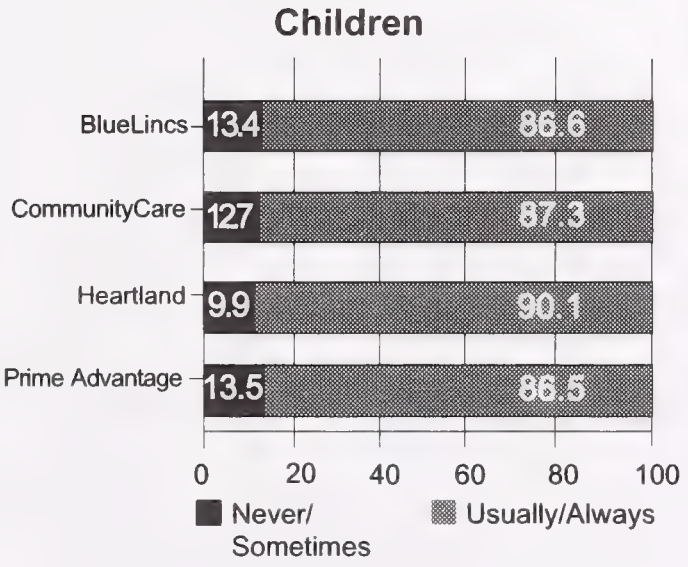
The percentages shown on the bars are the average of answers to the four survey questions listed above.

Courtesy, Respect and Helpfulness of Medical Office Staff

The survey asked people how often the office staff at their or their child's doctor's office or clinic:

- Treated them or their child with courtesy and respect
- Were as helpful as they should be





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❑ Yes ❑ No

❑ Yes ❑ No

❑ Yes ❑ No

❑ Yes ❑ No

Did this plan do well?

❑ Yes ❑ No

❑ Yes ❑ No

❑ Yes ❑ No

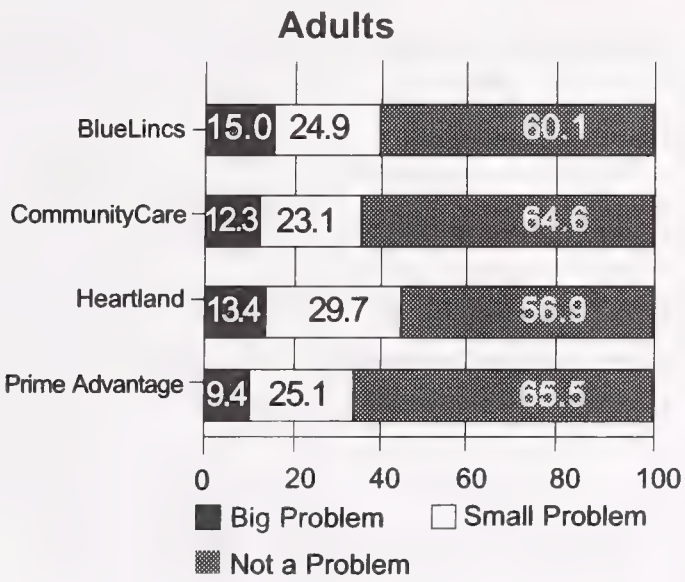
❑ Yes ❑ No

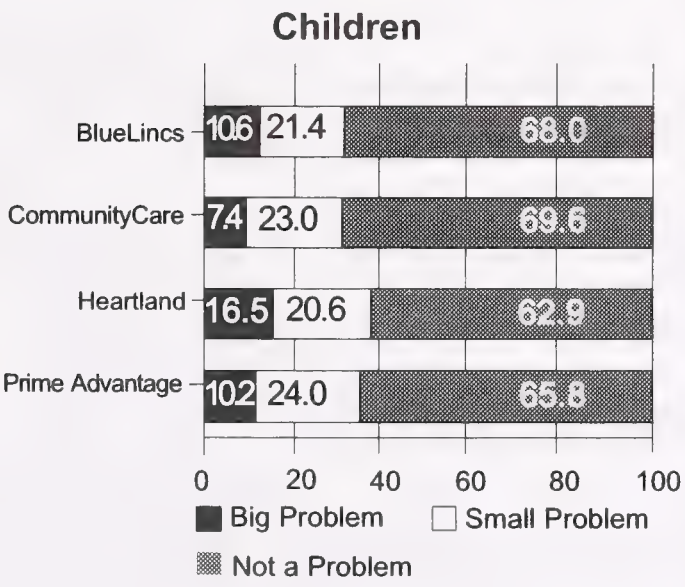
The percentages shown on the bars are the average of answers to the four survey questions listed above.

Experience with Health Plan Member Services, Information, Paperwork

The survey asked people how much of a problem, if any, it was to:

- Find or understand information in the written materials
- Get the help they needed when they called their or their child's health plan's member services
- Complete the paperwork for their or their child's health plan





YOUR WORKSHEET

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❑ Yes ❑ No

❑ Yes ❑ No

❑ Yes ❑ No

❑ Yes ❑ No

Did this plan do well?

❑ Yes ❑ No

❑ Yes ❑ No

❑ Yes ❑ No

❑ Yes ❑ No

The percentages shown on the bars are the average of answers to the four survey questions listed above.

How to Make a Decision

Step 1

List the health plans that did well in the areas you find important. These are the health plans that you checked "yes" for on pages 4-11.

Step 2

Check your enrollment packet to see if the health plan is available in your area. Members should note that BlueLincs is no longer available. Unicare Health Plan of Oklahoma is a new plan available to members in the Oklahoma City and Lawton areas.

Step 3

Call the health plan's member services for more information.

Here are some questions to ask about the health plans that you may be interested in joining.

About the plan's doctors...

- Can I keep seeing the doctor who I see right now?
- Are there doctors near where I live who can take me as a patient?

About the plan's services...

- Are any of the hospitals listed for this health plan near where I live?
- Where is the nearest pharmacy that I can use?

About your special needs...

If I have a special condition, can I get the same treatment or services that I get now?

Will my treatment for special conditions stop for any period of time if I join the health plan?

- Does the health plan have a provider who speaks my language?

About the plan benefits...

Are there other services covered by the health plan?

Check your enrollment packet for more information on the health plans available to you.

Helpful Numbers

Health Plan Member Services

CommunityCare HMO	**1-800-900-2690**
Heartland Health Plan	**1-800-492-7639**
Prime Advantage	**1-800-559-5532**
UniCare	**1-800-700-3341**

Oklahoma Health Care Authority Customer Services

1-405-522-7171 Oklahoma City area and out of state
1-800-522-0310 Statewide/out of Oklahoma City area
1-405-522-7179 (TDD/TTY) For hearing impaired only

Call when you have questions about benefits or billing.

SoonerCare Helpline

1-800-987-7767

Call to choose a health plan or request a change in a health plan. You also can call this number if you need enrollment materials or lose your OHCA permanent plastic medical identification card. The ***SoonerCare*** Helpline can provide general information about ***SoonerCare Plus.***

Call your local Department of Human Services (DHS) social worker if you have questions about eligibility, recertification or changes in address, name or family status.

Background

A total of 8,307 members of the ***SoonerCare Plus*** plan in Oklahoma were selected to participate in the survey. This number included 4,100 children and 4,207 adults. These members had been with their ***SoonerCare Plus*** plan for at least six months and were chosen to represent all members. Surveys were completed by 2,861 members, including 1,441 children and 1,420 adults.

- When the survey was about a child's experience, a parent or other adult answered.

- The survey was done by mail and telephone. Participation was voluntary and confidential.

- The surveys were done by participating HMOs that contracted with certified Consumer Assessment of Health Plans Survey (CAHPS) vendors.

- The Oklahoma Foundation for Medical Quality (OFMQ) analyzed the survey results. OFMQ and the Oklahoma Health Care Authority collaborated on the design of the report.

CAHPS

Health Care Quality Information from the Consumer Perspective

The consumer satisfaction survey was conducted by each Medicaid HMO through contracts with certified Consumer Assessment of Health Plans Survey (CAHPS) vendors. The survey and report were developed by the CAHPS consortium. The CAHPS project is sponsored by the Agency for Healthcare Research and Quality through cooperative agreements with:

- Harvard University
- The RAND Corporation
- Research Triangle

No presentation or handout materials were received from Dale Shaller prior to the meeting for inclusion in the handout binder.

No presentation or handout materials were received from Steven Garfinkel prior to the meeting for inclusion in the handout binder.

No presentation or handout materials were received from Kathy Coltin prior to the meeting for inclusion in the handout binder.

"CAHPS" for ARKids

Using CAHPS in Other Contexts

ARKids 1st

"CAHPS" for ARKids

- Overview of MMCS and ARKids First
- Project Design and Methodology
  - Survey Instrument
  - Sample Design
  - Data Collection
- Survey Challenges and Outcomes

ARKids 1st

Medicaid Managed Care Services

- A division of the Arkansas Foundation for Medical Care, Inc. (Ark. PRO)
- Provides Medicaid with utilization monitoring and quality assurance services

ARKids 1st

Recipient Relations

- Satisfaction Surveys
- Focus Groups
- Transportation Help Line
- Special Projects

ARKids 1st

ARKids First

- 1997 legislation created ARKids First
- Medicaid expansion waiver – precursor to CHIPS/SCHIPS
- Health insurance for children of working parents
- PCCM model (Primary Care Case Management)
- Currently covers 50,000+ children

ARKids 1st

Survey Instrument

- CAHPS 2.0 Child Medicaid Managed Care Questionnaire
- Survey 81 questions in length
- 3 of the 3 supplemental questions from Dental set
- 18 custom questions

ARKids 1st

Custom Questions - Topics

- PCP turnover
- Recipient access to PCP during after-hours and on weekends
- Recipient access to dental care
- How parents first learned about ARKids First
- Recipient access related to co-payments
- Medicaid enrollees in the ARKids First program

ARKids 1st

Sample Design

- Random sample of 1,500 parents or guardians
- 6 months of continuous enrollment from January 1, 2000 to June 30, 2000
- One survey per household
- Recipients selected through MMIS

ARKids 1st

Data Collection

- **CAHPS Survey Protocol**
- **Survey Method**
- **Data Entry Procedures**

ARKids 1st

Data Collection

- **CAHPS Survey Protocol**

	CAHPS	ARKids First
Advance Letter	mailed	mailed
Initial Round Survey	1 week	2 weeks
Reminder Card	10 days	24 days
Second Round Survey	1 week	1 week
Follow-up Activities	2 weeks	none

Data Collection

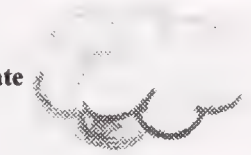
- **Survey Method**
  - Cover letter on State letterhead
  - Written questionnaire
  - Mail only
  - Bulk rate
  - Address correction
  - Self-addressed return envelope

Data Collection

- **Data Entry Procedures**
  - Surveys stamped with data received
  - MedQuest module used to track survey process and to enter data
  - All responses and comments keyed "as is"
  - Cleaning completed using SAS code prior to analysis

Survey Challenges

- **Customizing Questions**
- **Maximizing Response Rate**
- **Meeting Deadlines**



ARKids 1st

Survey Challenges

- **Customizing Questions**
  - Length of survey
  - Literacy of recipients
  - Validity of responses

ARKids 1st

Survey Challenges

- **Maximizing Response Rate**
  - Survey timeline
  - Address validity
  - Length of survey
  - Literacy of recipients
  - Lack of telephone contact

ARKids 1st

Survey Response Rates

	1998	1999	2000
Adjusted Survey Sample	1439	1438	1376
Adjusted Response Rate	58.3	51.5	50.9
Surveys Returned	919	814	795
Usable Surveys	839	741	701
Total Questions	84	73	81
Data Collection Period Ended	Nov	Jan	Jan

ARKids 1st

Survey Challenges

- **Meeting Deadlines**
  - Slow response rate
  - Process coordination
    - Staff
    - Equipment

ARKids 1st

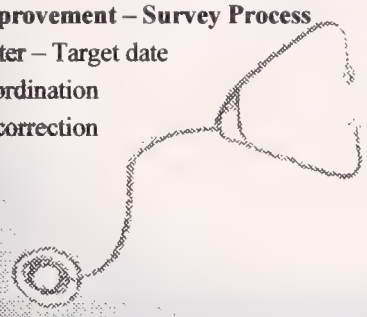
Outcomes

- **External quality review requirement met for Federal Waiver - HCFA**
- **Quality Improvement Opportunities**
- **Promoting ARKids First**

ARKids 1st

Outcomes

- **Quality Improvement – Survey Process**
  - Cover letter – Target date
  - Team coordination
  - Address correction



ARKids 1st

Outcomes

- **Quality Improvement – ARKids First**
  - Well-child visits
  - Immunizations
  - Dental survey

ARKids 1st

Outcomes

- **Promoting ARKids First**
  - Statewide
    - Providers
    - Decision Makers
    - Stake Holders
  - Nationally
    - Meetings
    - Conferences

ARKids 1st

No presentation or handout materials were received from Lorraine Brown prior to the meeting for inclusion in the handout binder.

No presentation or handout materials were received for the discussion session prior to the meeting for inclusion in the handout binder.

No presentation or handout materials were received from Cheryl Damberg prior to the meeting for inclusion in the handout binder.

Implementing CAHPS at the Care System and Clinic Level in Minnesota

Implementing CAHPS at the Care System and Clinic Level in Minnesota

Walter G. Suarez, MD, MPH
Executive Director
Minnesota Health Data Institute

Presented at the
Seventh National CAHPS Users Group Meeting
Las Vegas, Nevada - March 8-9, 2001

Minnesota Health Data Institute

About the Minnesota Health Data Institute

- Public-Private Partnership established in 1993
  - Created through enabling legislation
  - Incorporated as non-profit
- Board of Directors representing consumers, employers, providers, plans, researchers and policy makers
- Three core functions:
  1) Quality Measurement
  2) Data Privacy
  3) Health Care Electronic Commerce

The Health Care Market in Minnesota

- Population: 4.8 million
- Health Insurance:
  - 67% have private insurance (almost all through employers)
  - 24% covered by public programs (10% Medical Assistance; 14% Medicare)
  - Between 6%-9% uninsured
- Private Insurance:
  - 21% Traditional managed care
  - 17% PPOs
  - 29% Self-Insured

Implementing CAHPS at the Care System and Clinic Level in Minnesota

The Health Care Market in Minnesota

- Medicaid:
  - Approximately 60% in prepaid medical assistance with almost all MCOs participating
  - Remaining 40% under traditional fee for service
- Medicare:
  - Mostly fee for service; only a small proportion of Medicare covered by MCOs

The Health Care Market in Minnesota

- Managed Care Organizations (MCOs):
  - Four dominant health plans in the market
  - Four smaller health plans covering targeted population groups (Medicaid, Medicare)
  - Small percentage of population covered by traditional indemnity
- Large Health Care Purchasing Coalition
  - Buyers Health Care Action Group (BHCAG)
- Health Care Provider Groups
  - ~ 30 Large Health Care Delivery Systems
  - Contract overlaps with MCOs
  - Direct contracting with purchasing coalition

Forces Leading to Expanding Health Quality Survey Efforts

- Employer and consumer choices
  - 19% of employees offered 2 or more health plan choices (down from 43% in 1993)
  - Each health plan offering more health care delivery choices (doctors, clinics, hospitals)
  - Purchasing coalition offers ~ 24 health care delivery system choices to employees
- Provider overlap across health plans
  - Almost all providers participate in all major health plan networks
- Employer choice at health plan and care system level
- Consumer choice at care system/clinic level

Implementing CAHPS at the Care System and Clinic Level in Minnesota

Minnesota Health Data Institute Quality Measurement Program

- Purpose: To gather and disseminate comparative information about the quality of health care services in Minnesota
- Projects:
  - 1995: Consumer Survey of Health Plan
  - 1997: Medicaid CAHPS 1.0
  - 1998: Consumer focus groups assessing the value of clinic survey information
  - 1998: Clinic survey project in Northeast MN
  - 1999: Medicaid CAHPS 2.0
  - 1999: BHCAG/State Employee Survey project
  - 2001: Medicaid CAHPS 2.0
  - 2001: BHCAG/State Employee Survey project

2001 Project Overview

Two Project Components:

- DHS Medicaid, MinnesotaCare Health Care Quality Survey
  - Program and Health Plan Level Reporting for Medicaid and MinnesotaCare
- BHCAG/DOER Health Care Quality Survey
  - BHCAG - Care System Level Reporting
  - DOER - Care System plus Health Plan Level Reporting

2001 Project Overview

BHCAG/DOER Project Purposes:

- To assess and compare the experiences of employees enrolled in the various care systems (BHCAG and DOER) and health plans (DOER)
- To produce a report for consumers to use at open enrollment
- To prepare quality improvement reports for project sponsors (DOER and BHCAG) and participating health plans and care systems

Implementing CAHPS at the Care System and Clinic Level in Minnesota

2001 Project Features
~ *Survey Population* ~

- Adults (Metro/Non-metro):
  - 22 care systems jointly surveyed
  - 1 care systems BHCAG Only
  - 4 care systems DOER Only
  - 6 DOER Health Plans
- Children (Metro/Non-metro):
  - 23 care systems jointly surveyed
  - 1 care system BHCAG Only
  - 4 care system DOER Only
  - 6 DOER Health Plans

2001 Project Features
~ *Sample Files* ~

- Type: Random sample of 650 cases per care system (*)
- Source: Health Plans for DOER and Plan Administrator for BHCAG
- Criteria: Currently enrolled to receive care at a clinic in the care system and have at least one primary care visit during the last 12 months
- Targets:
  - Target Response rate: 50%
  - 325 adults per care system
  - 325 children per care system

(*) Random samples will be re-distributed according to health plan enrollment for health plan survey component

2001 Project Features
~ *Roll-up Sampling Strategy* ~

- Sampling and survey is done at the care system level
- An identifier of the health plan the person is enrolled in is kept by vendor
- Vendor controls samples to ensure that enough numbers are available for each health plan across all care systems
- A first analysis is done at the care system level
- All samples are then aggregated and the full set is reorganized by health plan
- A second analysis is then performed by health plan

Implementing CAHPS at the Care System and Clinic Level in Minnesota

2001 Project Features
~ *Survey Instrument* ~

- G-CAHPS: A revised provider adaptation of CAHPS instrument.
- Composed of approximately 75 questions and includes:
  - -- Global ratings:
    - Health plan, health care, clinic, doctor/nurse.
  - -- Composite Questions:
    - Care System: Doctor Communication, Referrals and Care, Office Staff, Care without Long Waits.
    - Health Plan: Getting Needed Care, Plan Customer Service

2001 Project Features
~ *Survey Instrument* ~

➪ New Survey Questions:

Expanded questions about personal doctor or nurse

- Explaining tests results
- Explaining the purpose of new prescriptions
- "Talking to you about..." Diet, Exercise, Stress
- Knowing you as a person
- Trusting their judgement about your care
- Putting your health and well-being above cost
- Being informed and up-to-date about your care from specialists

2001 Project Features
~ *Survey Methodology* ~

- 10-Week field period (February-May, 2001)
- Standard CAHPS ™ 2.0 three-wave mail plus phone follow-up protocol
- Waves:
  - 1st mailing with cover letter
  - Postcard reminder
  - 2nd mailing with cover letter to non-responders
  - Telephone follow-up until target completion rates are met

Implementing CAHPS at the Care System and Clinic Level in Minnesota

2001 New Project Features

- Participation of the University of Minnesota employees and their dependents
- Implementation of a disenrollment survey for health plan and care system

2001 Project Deliverables and Data Products

- Reports for Employees
  - 2001 BHCAG Health Care Quality Report
  - 2001 DOER Health Care Quality Report
- Health Plan and Care System Products:
  - Raw Data Files
  - Stub-and-Banner Tabulation Reports
  - Quality Improvement Reports

2001 Project Deliverables and Data Products

Reports to Employees

- Final format under development
- Probably will have similar features to 1999 Reports
  - 1-2-3 symbol-ratings
  - Bar-chart reports
- Expect to include expanded comparisons to national benchmarks
- Reports would be mailed to State employees and employees of the member companies of BHCAG in the fall of 2001, as part of the open enrollment materials for 2002.

Implementing CAHPS at the Care System and Clinic Level in Minnesota

2001 Project Deliverables and Data Products

Raw Data Files and Stub and Banner Reports

- Raw data files will be delivered to each health plan and care system in an excel file.
- Stub and Banner reports will be delivered as text files.
  - Each health plan and care system will receive item-by-item results for their population.
  - Report banners will include age, gender, health status, race/ethnicity, and overall ratings for clinic, health care, and doctor/nurse.

2001 Project Deliverables and Data Products

Quality Improvement Reports

- Contains question-by-question results with detailed analysis of areas of strength and priority areas for improvement
- Correlates the size of of 'problem' score to overall satisfaction
- Compares:
  - Individual health plans and care system results
  - Masked results for the other groups
  - Comparison group benchmark (metro or non/metro)
  - Comparison group average (metro or non/metro)

Key QI Report Concepts

Priority Matrix

Getting Care Without Long Waits

Implementing CAHPS at the Care System and Clinic Level in Minnesota

Key Project Issues

- Funding:
  - Project funding provided by sponsors (BHCAG, DOER)
  - No funding available for statewide implementation
- Lack of Statewide Comparisons:
  - No statewide results or reports available for commercial populations
- Complexity of project:
  - Multiple care systems samples (adult, children, metro, non-metro)
  - Controlling care system samples to ensure enough numbers for health plan roll-up analysis

Key Project Issues

- Survey coordination efforts
  - Use of G-CAHPS vs CAHPS 2.0H limited ability to coordinate efforts with health plans
- Differences between metro and non-metro populations
  - Separate benchmark comparisons for metro and non-metro needed in 1999

Thank You!

Questions and Answers

Michael D. Hays
President & CEO
National Research Corporation

Evolution of Measurement

Plan Results

Group Results

Individual Physician Results

NRC DoctorGuide

- ***A patient satisfaction program that creates individual physician profiles grounded upon both business and scientific principles***

DOCTORGUIDE

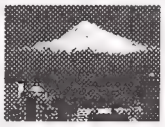
Demonstration Projects

- Portland, Oregon
- Cincinnati, Ohio

- Timetable
  - Portland - Surveys Mailed August
  - Cincinnati - Surveys Mailed February

Portland Demonstration - Facts

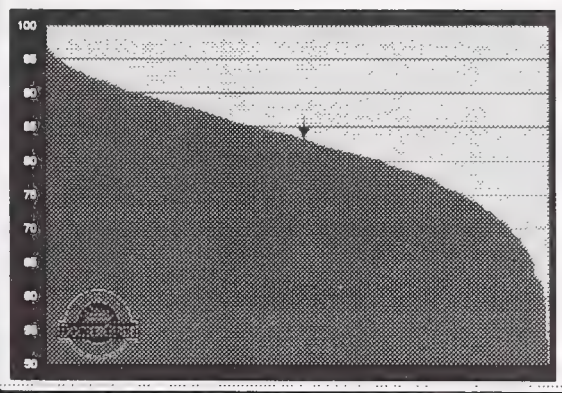
- Data pooled from three leading health plans
- Over 90,000 Portland households received DoctorGuide survey



- High overall response rate (40.0%)

- Profiles of over 430 PCPs now available to
  - Employers
  - Plans
  - Physicians
  - Consumers

Communication Theme Variance



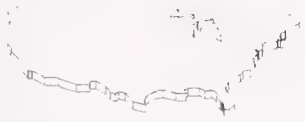
Portland Results

- NRC awards DoctorGuide Seal, by theme, to those providers at or above community benchmark

- Since January, over 36,000 consumers have visited DoctorGuide.com.

Next Steps

- CAHPS® Field Test - Cincinnati
  - Comparison of 100 physicians using:
    - Selected items from CAHPS ® Group Level Tool
    - NRC DoctorGuide

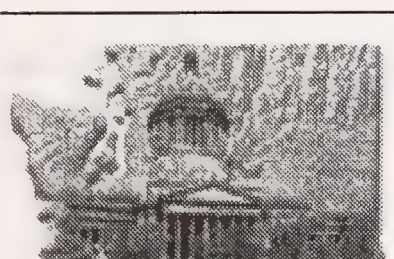


- National Roll-out
  - Top 100 MSAs
  - 100,000 Primary Care Providers

REPORTING GUN RESULTS

No presentation or handout materials were received for the discussion session prior to the meeting for inclusion in the handout binder.

No presentation or handout materials were received from Nora Wells prior to the meeting for inclusion in the handout binder.



Washington State Medicaid Program

Children with Special Health Care Needs

CAHPS Reporting

Reporting on Children with Special Health Care Needs

* Measures available for reporting
* Choosing **which** measures to report
* Choosing **how** to report these measures
* Follow-up to reporting

1

Measures we collected

- Access to prescription medicine
- Access to specialized services
- Coordination of care
- Family-centered care

2

Measures:

Access to Rx medicines

- Basic question about access to prescription medicine: *Big problem/Small problem/Not a problem*
- Follow up question: Did anyone help with this problem?
- Follow up allows you to increase score to give credit for providing assistance

3

Measures, continued:

Access to specialized services

- Problems accessing medical equipment
- Problems accessing specialized therapies
- Problems accessing treatment or counseling
- Allows credit for help with problem

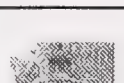
4

Measures, continued:

Coordination of care

- For children who need help at school with health care, *how much of a problem was getting your child's doctors to help your child's school understand these needs?*
- For children who get care from more than one provider or service, *does anyone help you to coordinate your child's care among these different providers and services?*

5



Measures, continued:

Family-centered care

HOW OFTEN DOES YOUR...

- Doctor understand how medical conditions affect day to day life?
- Doctor talk with you about how child is feeling, growing, or behaving?
- Provider(s) give support about care you provide?
- Provider(s) involve you in decisions?
- Provider(s) give you needed information?

6

Measures, continued:

Family-centered care

HOW MUCH OF A PROBLEM...

- Was getting your child's doctors or other health providers to listen to your concerns about the best way to manage your child's medical or health problems?
- Was getting your child's doctors or other providers follow up on concerns about your child's medical or health problems?

7

Choosing which measures to report: **Input**

- Stakeholders
- Partners in project
- Contractors
- Interested parties

8

Choosing which measures to report: **Criteria**

- Keep the response categories alike
- OK to group questions about providers and doctors; dropped credit for help provided
- Assumptions based on budget & CAHPS standard analysis
- Prioritize based on expert opinion (what's important to families) and prior testing

9

Decisions about *how* to report: **Input**

- Survey partners
- Stakeholders
- Experts in the field
- Interested parties
- Contractors

10

Options for reporting

- Absolute vs. relative for client report
- CAHPS standard or FACCT method
- Adding survey measures from new surveys (Promoting Healthy Development and Young Adult Health Care Survey)
- Adding non-survey measures (EPSDT and immunizations)

11

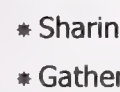
Different presentation: same data

12

Decisions on reporting

- Report CAHPS/CSHCN survey measures only (not EPSDT or immunizations)
- Report comparative results in "star charts" for clients (similar to previous years)
- Produce separate reports for stakeholders with absolute values and detailed findings

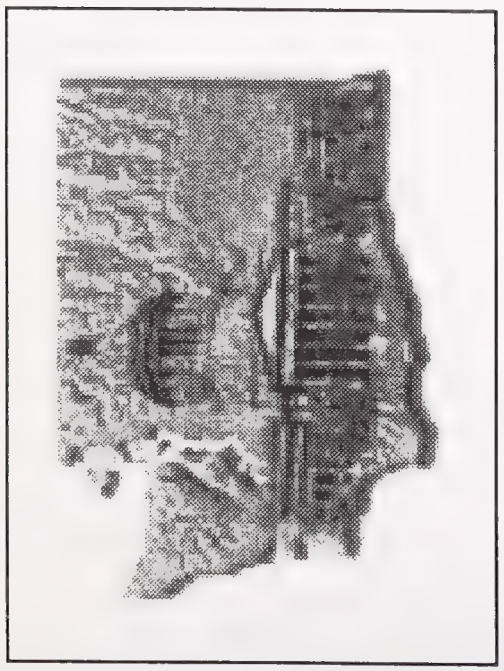
13



Follow-up

- Sharing results widely
- Gathering response formally and informally
- Using for health plan quality improvement
- Preparing for BBA regulations

14



CARPS Project Profiles

Evaluating Delivery Systems

Description of Posters

Description of Demonstrations

Satisfaction with Managed Care in the Adult SSI Population

Darendia McCauley, Ph.D.
Oklahoma Health Care Authority

Terry Winston
Oklahoma Foundation for Medical Quality
Survey Administration and Data Analysis

Satisfaction Surveys in Oklahoma

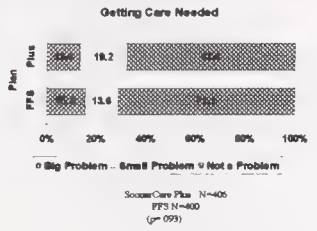
- Consumer satisfaction surveys have become an important source of information to health care purchasers and consumers of health care and to the health care organizations themselves.
- The Oklahoma Health Care Authority has conducted the Consumer Assessment of Health Plan Survey (CAHPS) for the Medicaid population in Oklahoma for several years.

CAHPS Continued:

- OHCA has administered the Adult SSI CAHPS survey prior to (FFS) and after enrollment of the population into managed care (SoonerCare Plus).
  - Provides for monitoring of the health care delivery system
  - Provides for comparison of satisfaction with a traditional Medicaid FFS setting and a managed care setting

Getting Needed Care

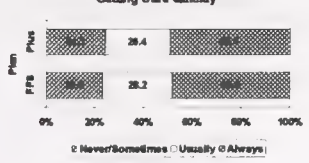
- With the choices your health plan gives you, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?
- In the last 6 months, how much of a problem, if any, was it to get a referral to a specialist that you needed to see?
- In the last 6 months, how much of a problem, if any, was it to get the care you or your doctor believed necessary?
- In the last 6 months, how much of a problem, if any, were delays in health care while you waited for approval from your health plan?



SoonerCare Plus N=405
FFS N=400
(p= 093)

Getting Care Quickly

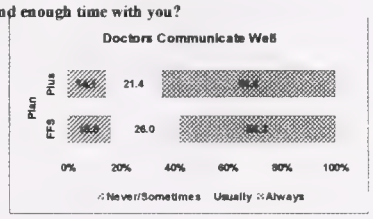
- In the last 6 months, when you called during regular office hours, how often did you get the help or advice you needed?
- In the last 6 months, how often did you get an appointment for regular or routine health care as soon as you wanted?
- In the last 6 months, when you needed care right away for an illness or injury, how often did you get care as soon as you wanted?
- In the last 6 months, how often did you wait in the doctor's office or clinic more than 15 minutes past your appointment time to see the person you went to see?



SoonerCare Plus N=406
FFS N=395
(p= 837)

Doctor's Communication

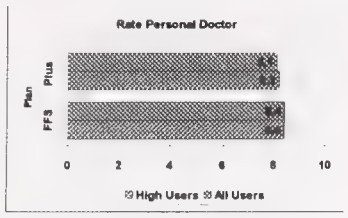
- In the last 6 months, how often did doctors or other health providers listen carefully to you?
- In the last 6 months, how often did doctors or other health providers explain things in a way you could understand?
- In the last 6 months, how often did doctors or other health providers show respect for what you had to say?
- In the last 6 months, how often did doctors or other health providers spend enough time with you?



SoonerCare Plus N=342
FFS N=349
(p= 228)

Overall Rating of Doctor

- **Use any number on a scale from 0 to 10 where 0 is the worst personal doctor or nurse possible, and 10 is the best personal doctor or nurse possible. How would you rate your personal doctor or nurse now?**

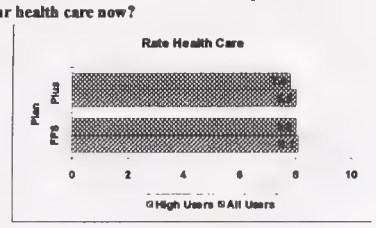


SoonerCare Plus N=340
FFS N=351
(p=.216)

SoonerCare Plus High Users N=179
FFS High Users N= 199
(p=.333)

Rating of Health Care

- **Use any number on a scale from 0 to 10 where 0 is the worst health care possible, and 10 is the best health care possible. How would you rate all your health care now?**

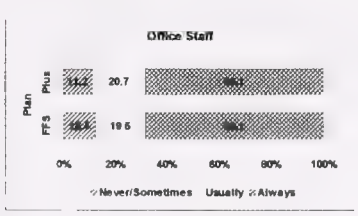


SoonerCare Plus N=337
Fee-For-Service N=344
(p=.275)

SoonerCare Plus High Users N=215
Fee-For-Service High Users N=235
(p=.505)

Office Staff

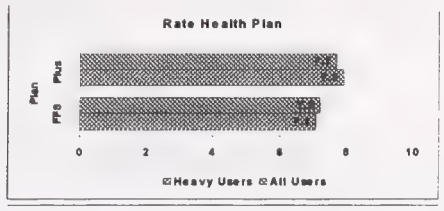
- **In the last 6 months, how often did office staff at a doctor's office or clinic treat you with courtesy and respect?**
- **In the last 6 months, how often were office staff at a doctor's office or clinic as helpful as you thought they should be?**



SoonerCare Plus N=140
FFS N=150
(p=.8461)

Rating Health Plan

- **Use any number from 0 to 10 where 0 is the worst health plan possible, and 10 is the best health plan possible. How would you rate your health plan?**

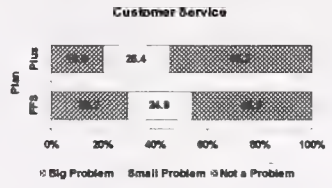


SoonerCare Plus N=440
FFS N=461
(p 007)

SoonerCare Plus High Users N=210
FFS High Users N=238
(p= 001)

Customer Service and Paperwork

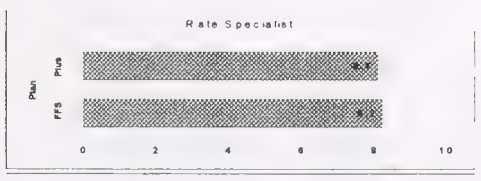
- **In the last 6 months, how much of a problem, if any, was it to find or understand information in the written materials?**
- **In the last 6 months, how much of a problem, if any, was it to get the help you needed when you called your health plan's customer service?**
- **In the last 6 months, how much of a problem, if any, did you have with paperwork for your health plan?**



SoonerCare Plus N=238
FFS N=145
(p= 096)

Rating of Specialist

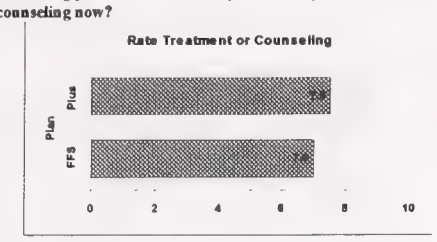
- **Use any number on a scale from 0 to 10 where 0 is the worst specialist possible and, and 10 is the best specialist possible. How would you rate specialist now?**



SoonerCare Plus N=160
FFS N=162
(p= 681)

Behavioral Health

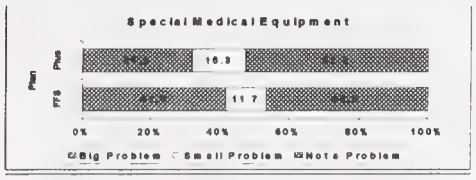
- **Use any number on a scale from 0 to 10 where 0 is the worst treatment or counseling possible, and 10 is the best treatment or counseling possible. How would you rate all your treatment or counseling now?**



SoonerCare Plus N=111
FFS N=100
(p= 228)

Medical Equipment

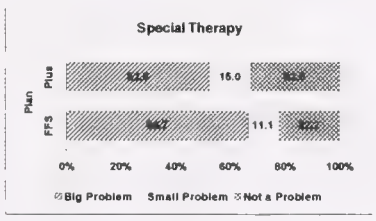
- **In the last 6 months, how much of a problem, if any, was it to get the special medical equipment you needed through your health plan?**



SoonerCare Plus N=72
FFS N=77
(p= 455)

Getting Special Therapy

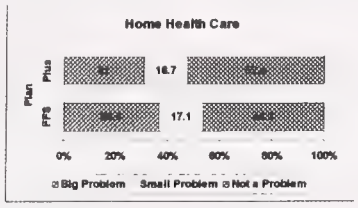
- **In the last 6 months, how much of a problem, if any, was it to get the special therapy you needed through your health plan?**



SoonerCare Plus N=40
Fee-For-Service N=36
(p=.45)

Home Health Care

- In the last 6 months, how much of a problem, if any was it to get home care or assistance you needed through your health plan?



SoonerCare Plus N=42
Fee-For-Service N=41
(p= .382)

Summary

- **Adult SSI Medicaid recipients respond favorably to a managed care health delivery system when compared to a fee-for-service health delivery system.**
  - There were no significant differences in responses to "Getting needed care" items, except in "awaiting approval from the health plan". This is understandable from the perspective that there was no need for approval in a fee-for-service setting.
  - There were no significant differences in response items to "Getting care quickly" measures.
  - There were significant differences in "Doctors Communicate well" measures. Managed care doctors rated significantly higher in "providers explaining in a clear way" and "providers showing respect".

Summary Continued:

- There were no significant differences in response to "Courteous and respectful office staff" measures.
- There were significant differences in "Experiences with customer service, information, and paperwork" measures. Managed care plans rated significantly higher in "understanding written information" and "helpful customer service" measures. While there was a difference in "completing health plan paperwork", this is, again, understandable from the perspective that there was no plan paperwork in fee-for-service.
- There were no significant differences in SSI specific questions regarding "obtaining medical equipment", "getting special therapy", and "getting home care and assistance".

Summary Continued:

- There were no significant differences in SSI specific questions related to "rating of personal doctor or nurse", "rating of specialist", "rating of treatment or counseling", or "rating of health care".
- There were significant differences in "rating health plan", with managed care plans rating significantly higher than fee-for-service among all users. This difference was even higher among high users of service.
- While there were not significant differences in Behavioral Health, Medical Equipment, Special Therapy, or Home Health measures among respondents, managed care scored consistently higher than fee-for-service.

No presentation or handout materials were received from Jim Borton prior to the meeting for inclusion in the handout binder.

No presentation or handout materials were received from Eric Jacobson prior to the meeting for inclusion in the handout binder.

CAHPS Project Profiles
CAHPS Bibliography
Description of Posters
Description of Demonstrations

Author: Julie Brown

Organization RAND

Title: Dental CAHPS: Exploring Domains of the Dental Care Experience of Children Enrolled in California's Medi-Cal and Healthy Families Programs

Summary: Key findings from two focus groups on the dental care experiences of children in California's Medicaid program (known as Medi-Cal) and Healthy Families programs. Group participants are parents of these children. The poster will share findings about access to care, reports of positive and negative care experiences, and key instrument domains explored in the groups. In addition, participants will review and discuss a set of draft items during the course of each group. A copy of the draft item set will be available during the User Group Meeting.

Author: Ron D. Hays

Organization RAND/UCLA

Title: A Chiropractic Supplemental Item Set for the Consumer Assessment of Health Plans Study

Summary: A set of items was drafted based on the literature in chiropractic and previously tested patient instruments for assessing chiropractic care. In addition, focus groups were held in both English and Spanish to ascertain those dimensions of care and plans thought to be important to chiropractic patients. Preliminary survey items were evaluated in one-on-one cognitive interviews with patients. A survey instrument was developed and administered to a sample of 462 enrollees in the Uniform Medical Plan who had used chiropractic care. A total of 324 mail questionnaires were completed (60% response rate). Correlations between 24 items targeting specific aspects of chiropractic and a global rating of chiropractic care ranged from 0.15 to 0.85. Based on these results and substantive considerations, we identified 10 items that we recommend for consideration as a CAHPS® supplemental item set.

Author: Walter Suarez
Julie Apold

Organization Minnesota Health Data Institute

Title: Differences Across Minnesota Health Plans in the CAHPS Adult Medicaid Survey Results by Race

Summary: The analysis is based on the 1999 consumer assessment of health plans serving Public Programs in Minnesota. The survey project included four public program population groups: 1) Medicaid managed care; 2) Medicaid fee-for-service; 3) MinnesotaCare; and 4) Minnesota Senior Health Options. The size of the distribution of minority respondents who responded to the survey supported further analysis of survey results by race for each health plan included in the Medicaid managed care component of the project. This analysis is designed to compare and contrast the answers given in response to the CAHPS™ 2.0H survey questions by three race groups, Whites, Black/African Americans and Asians, across the 6 health plans participating in the Medicaid managed care program.

Author: Tim Nanneman, Roper Starch Worldwide
Cheryl DeMars, The Alliance

Title: The Alliance and Employers' Health Care Cooperative CAHPS Study in Wisconsin

Summary: Poster includes copies of the QualityCounts Medical Group Report for Wisconsin, as well as, copies of the Project Overview and Detailed Results Medical Group Report.

Author: Rena Manning
Carla Morita

Organization Texas Health Quality Alliance

Title: Consumer Satisfaction in El Paso, Texas: Pre-and Post-Medicaid Managed Care Implementation

Summary: A poster based on THQA's survey in El Paso, TX. The purpose of the survey is twofold: 1) to provide evaluation and discussion of consumer satisfaction with physical and behavioral healthcare under Medicaid Managed Care (MMC) during its initial year of implementation in the El Paso Service Delivery Area (SDA); and 2) to compare consumer satisfaction with these services under MMC to consumer satisfaction with these services under the Traditional Fee-For-Service Medicaid (FFS).

Author: Carla Bann

Organization RTI

Title: Differential Item Functioning: Potential Population Differences within the CAHPS Medicare Fee-for-Service Field Test

Summary: Item response theory analyses were conducted to explore whether items on the CAHPS fee-for-service survey function differently for two groups: (1) beneficiaries under age 65 who are eligible for Medicare due to disability or end-stage renal disease and (2) beneficiaries aged 65 years old or older who are eligible for Medicare due to age. Analyses were based on data from 3,885 Medicare beneficiaries enrolled in fee-for-service health plans.

Author: Tim Nanneman, Roper Starch Worldwide
Becky Schwarz, New Mexico Human Services Department

Title New Mexico Medicaid Study

Summary: Poster will include an overview of New Mexico's current CAHPS activities. A Methodological Highlights handout will be available.

Author: Janice Ricketts, Westat
Dale Shaller, QMAS

Title: The National CAHPS Benchmarking Database (NCBD)

Summary: The poster will include general information and materials regarding the National CAHPS® Benchmarking Database (NCBD). We will have sample reports, data displays, data submission information and newsletters on display. Additionally, staff will be on hand during the poster session (March 8, 4:40-7:00p.m.) to answer questions.

Author: Nancy D. Berkman

Organization RTI

Title: The Impact of CAHPS Survey Data on an Employed Population

Summary: This study assesses the impact of the CAHPS ratings, contained in the CAHPS comparative, report on employee's choice of health plans. Two study sites are compared. One is a large private employer in Oregon and the second is the State of Kansas. A CAHPS report was distributed to employees in demonstration sites using a pre-post, comparison group quasi-experimental design.

Author: Scott Scheffler

Organization RTI

Title: Using CAHPS to Compare Plans: What do the Stars Tell Us?

Summary: CAHPS Star Charts are used to compare individual plan means for an individual questionnaire item (or composite of items) against the average of all the plans. Despite explicit instructions that the stars are not to be used to compare individual plans against each other, a natural temptation when examining the Star Charts is to conclude: *Because Plan A has two stars and Plan B only has one star, Plan A must be significantly better than plan B.* Our research investigates the implications of (mis-)using the CAHPS Star Charts for the purpose of comparing individual plans against each other rather than against the average of the plan means.

Author: Terry Winston

Organization Oklahoma Foundation for Medical Quality, Inc.

Title: Satisfaction in the Aged, Blind, and Disabled Medicaid Population Pre- and Post – Transition into Managed Care

Summary: Pre- and post- measurement of client satisfaction in the ABD (Aged, Blind, Disabled) Medicaid population in Oklahoma show small differences except in how the health plans were rated. The health plan was rated significantly higher under managed care than under fee for service.

Author: Mark Spranca

Organization RAND

Title: RAND's Health Cost Calculator: A Demonstration

Summary: A web-based tool that helps consumers to estimate their out-of-pocket health costs in the plans available to them.

Author: Tory Sherrill

Organization Applied Survey Knowledge

Title: ASK for Quick Results: A demonstration

Summary: Demonstration of the ASK software application for obtaining knowledge about an organization through feedback from their customers. The survey module containing the CAHPS Adult Core V2.0 questionnaire, as well as the ability to add user defined questions will be demonstrated. The survey question module will be demonstrated on the hand held input device and the report generator will be demonstrated on a standard PC.

Author: Kerri Yoder

Organization Westat

Title: www.talkingquality.gov: A Demonstration

Summary: TalkingQuality.gov is a resource for organizations involved in projects to educate and inform consumers about health care quality. To help sponsors of comparative quality reports pursue their goals more effectively, this site combines real-world examples, the latest research findings, and innovative ideas on ways to communicate complex information on health care quality to consumers. Through this comprehensive reference manual and planning tool, sponsors have access to insights into state-of-the-art activities well as the current evidence on what works well with consumers.

The material in the site is divided into five main sections:

- *The Big Picture:* An overview of what's involved in conducting a typical quality measurement project. This section provides the foundation for exploring the more specific communication issues presented in the rest of the site.

- *What to Say:* A discussion of what consumers need to hear about health care quality and the information sponsors may want to give them.

- *How to Say It:* An in-depth look at strategies for presenting information in ways that facilitates comprehension and use.

- *Into the Hands of Consumers:* An overview of effective strategies for building interest in quality information, distributing the information to consumers, and supporting their efforts to use the information to make decisions

- *Refining What You Do:* A look at how sponsors can improve their materials by testing them with audiences during the developmental stages and evaluating them formally after distribution.

The contents of this site were produced by the Workgroup on Consumer Health Information, a group of researchers with expertise in quality reporting, current sponsors of reporting projects, and recognized experts from related fields. The group was convened by a trio of federal government agencies with substantial interest in these issues: the Health Care Financing Administration (HCFA), the Agency for Healthcare Research and Quality (AHRQ), and the Office of Personnel Management (OPM).

Overview

The CAHPS User Group has grown from four early users and three demonstration sites in 1997 to a robust and active network of users. The User Group includes the largest federal health care purchasers (HCFA, OPM, Department of Defense), Medicaid agencies, state employee benefits offices, other state agencies conducting state wide surveys, purchasing coalitions, private employers, and health plans who are either conducting CAHPS for their own quality improvement purposes or to meet accreditation requirements. The Survey Users Network has grown to the point where only two states, Wyoming and North Dakota, conduct no CAHPS.

Table 1 below provides a quick look at the composition of sponsors, as of February 2001, registered with the CAHPS Survey Users Network(SUN).

Table 1

Sponsor	Number of Sites
State Medicaid Agencies	30
Other State Initiatives	18
Federal Agencies {OPM, HCFA, DoD}	3
Health Plans	47
Purchasing Coalitions	8

The following pages are dedicated to CAHPS projects conducted in the year 2000. This includes a table and map depicting populations surveyed by CAHPS. In addition, nine CAHPS project profiles are presented in more detail.

The exchange of ideas and experiences is key in developing and implementing CAHPS. In sharing project profiles, we hope that all users can learn from the experiences of others.

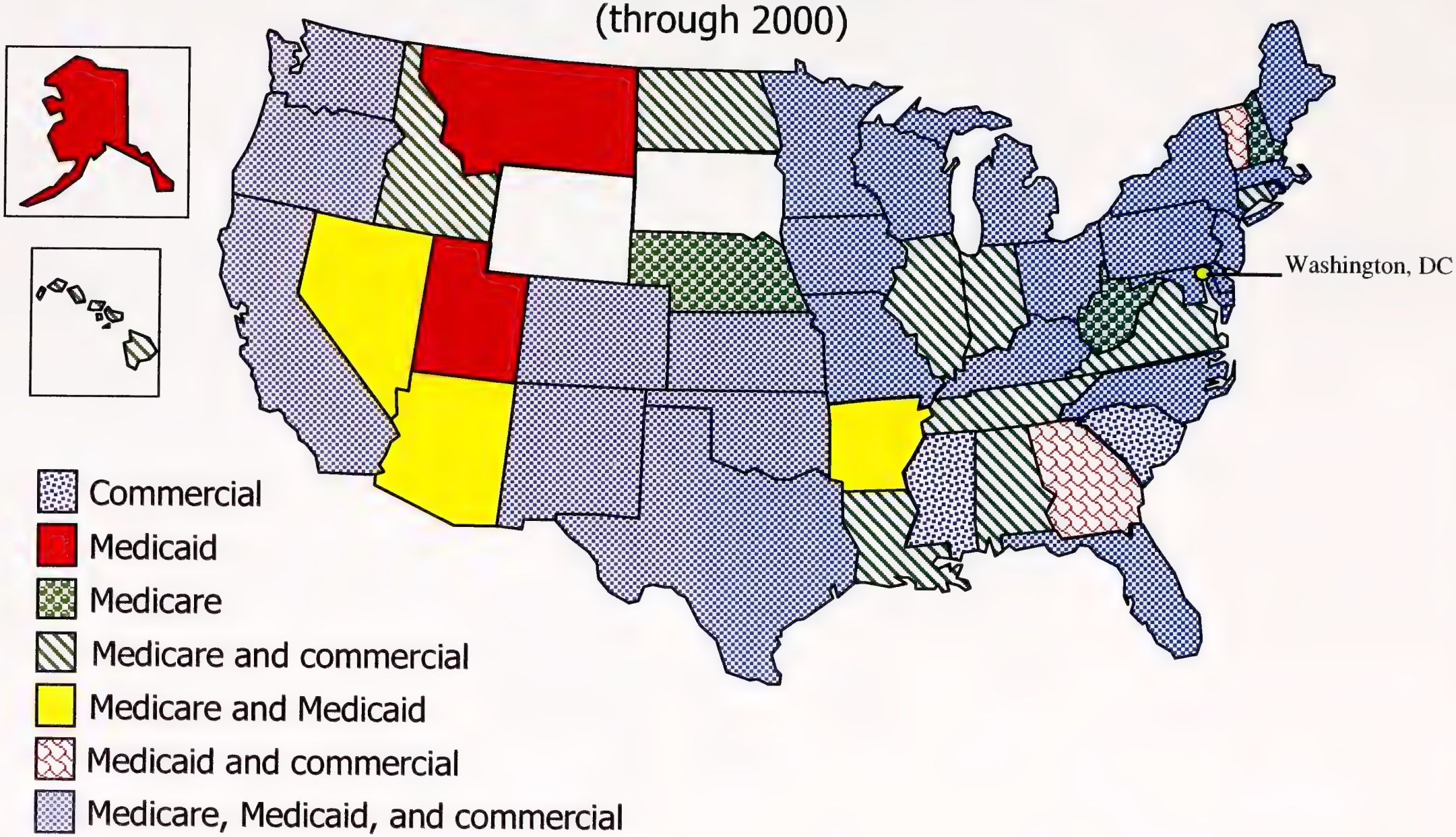
Organization	Population Surveyed		
	Medicare	Medicaid	Commercial
Access Alliance of Michigan			X
Advantage Health Plan		X	
Alaska Department of Health and Social Services		X	
Albert Einstein Medical Center	X	X	X
American Medical Group Association			X
Anthem Blue Cross Blue Shield of New Hampshire			X
Arizona Health Care Cost Containment System		X	
Arkansas Foundation for Medical Care		X	
Arkansas Mental Health Services Division		X	
Blue Cross Blue Shield Association	X		
Blue Cross Blue Shield of Delaware			X
Blue Cross Blue Shield of Maine			X
Blue Cross Blue Shield of Massachusetts	X		
Blue Cross Blue Shield of Montana		X	
Blue Cross Blue Shield of North Carolina			X
Blue Cross of Idaho			X
Bluegrass Family Health			X
Bureau of Managed Health Care			X
Buyer's Health Care Action Group			X
California Department of Health Services		X	
California Division of Managed Care	X	X	X
CalOPTIMA		X	
CareFirst Blue Cross Blue Shield (MD) (1999)	X	X	X
CareOregon, Inc.		X	
CARS Project	X		X
Case Western Reserve University		X	
Center for Naval Analyses			
Central Florida Health Care Coalition			X
Cigna HealthCare			X
Cimarron Health Plan and Health Care Horizons, Inc.		X	X
City of Sarasota			X
Colorado Access			X
Colorado Business Group on Health			X
Colorado Dept. Of Health Care Policy And Financing		X	
Columbus Health Department	X	X	X

Organization	Population Surveyed		
	Medicare	Medicaid	Commercial
Community Health Options (CHO)			X
Community Voices Evaluation Team	X	X	X
Contra Costa Health Plan		X	
D.C. Chartered Health Plan (1999)		X	
Dean Health Plan			X
Delaware Health Care Commission			X
Department of Defense			
Employers Health Cooperative, Janesville, WI			X
Florida Agency for Health Care Administration		X	
Ford Motor Company			X
Gateway Health Plan		X	
Georgia Department of Medical Assistance		X	
Greater Detroit Area Health Council			X
Hawaii Health Information Corporation			X
Health Care Financing Administration	X		
Health Care Plan	X	X	X
HealthCare 21 Business Coalition			X
HealthGuard of Lancaster, Inc			X
HealthLink			X
HealthPlus of Michigan		X	
Heartland Health Plan of Oklahoma		X	
Highmark Blue Cross Blue Shield	X		X
Iowa CAHPS Projects		X	X
Johns Hopkins Health Care			X
Kaiser Foundation Health Plan, Inc.			X
Kansas Foundation for Medical Care	X	X	X
Keystone Health Plan Central	X		X
Keystone Mercy Health Plan		X	
Maine Bureau of Health		X	
Managed Risk Medical Insurance Board (CA)		X	X
Maryland Health Care Commission			X
Massachusetts Division of Medical Assistance		X	
Maximus, Inc.		X	
Mercy Health Plan		X	
Michigan Department of Community Health		X	
Minnesota Department of Employee Relations			X

Organization	Population Surveyed		
	Medicare	Medicaid	Commercial
Minnesota Department of Human Services		X	
Missouri Department of Health		X	
New Jersey Department of Health and Senior Service			X
New Jersey Medicaid		X	
New Mexico Health Policy Commission			X
New York State Department of Health		X	
North Carolina Department of Insurance			X
North Carolina Division of Medical Assistance		X	
Office of Personnel Management (OPM)			X
Office of Vermont Health Access		X	
Ohio Department of Human Services		X	
Oklahoma Health Care Authority (1999)		X	X
Oregon Health Plan Policy and Research Office			X
Oregon Medical Assistance Programs		X	
Pennsylvania Department of Health			X
Preferred Care, Inc.	X		X
Providence Health Plan		X	X
QualChoice of North Carolina	X		
Rochester Health Commission	X		
Sierra Health Services, Inc.	X		X
Texas Department of Health		X	
Texas Health Care Information Council			X
The Alliance			X
The George Washington University Hospital		X	X
Tri-State Health Care Coalition			X
Tufts health plan			X
United Health Care Corporation	X	X	
Unity Health Plans			X
US Healthcare (New Jersey)		X	
Utah Department of Health		X	
Vermont Employers Health Alliance			X
Washington State Health Care Authority			X
Washington State Medical Assistance Administration		X	
Westchester Prepaid Health Services Plan		X	
Wisconsin Department of Employee Trust Funds			X
Wisconsin Department of Health and Family Services		X	

Populations Surveyed by CAHPS, as reported to the CAHPS Survey Users Network

(through 2000)



Organization	Minnesota Department of Human Services
Contact	Walter Suarez, Minnesota Health Data Institute (MHDI) E-mail: walter.suarez@mhdi.org

In its third year of conducting CAHPS, the Minnesota Department of Human Services conducted a consumer survey of beneficiaries in the Prepaid Medical Assistance Program (PMAP), Medical Assistance Fee-for-service, MinnesotaCare, and the Minnesota Senior Health Options (MSHO) program. Minnesota has also participated in the National CAHPS Benchmarking Database.

The intent of their CAHPS project was to assess, compare, and report the experiences of beneficiaries enrolled in these programs at the program and health plan levels. The Medicaid PMAP population includes a child segment (0 to12 years) and adult segments (18 to 64, 65 and over) stratified by health plan and metro/non metro. The MinnesotaCare population contains adults stratified by health plan and metro/non metro. The Medicaid Fee for Service population consists of a child population (0 to 12) and adult population (18 to 64, 65 and over) in non-metro area only. Finally the Minnesota Senior Health Options includes only people 65 and over in a metro area.

MHDI will use CAHPS 2.0H for all managed care cells and CAHPS 2.0 FFS for Medicaid Fee-for-Service cells. All instruments will include the SF-12 to assess the functional status of the population. Mode of data collection will occur in a four-wave mail plus telephone follow-up protocol. The possibility of conducting phone interviews using non-English versions of the CAHPS instrument upon request, as well as methods to better target and improve response rates in the young adult (18 to 35) Medicaid population are being explored. Results will be analyzed by age and metro/non metro.

Project Planning began in September 2000, with data collection between February and May 2001. A summary report of results is expected in October 2001.

Organization	Delaware Health Care Commission
Contact Person	Eric Jacobson, University of Delaware E-mail: ericj@udel.edu

The Delaware Health Care Commission conducted its third CAHPS survey in 1999. Delaware has also participated in the National CAHPS Benchmarking Database.

The 1999 Delaware CAHPS project lasted from January to December of 1999. The survey results were summarized in the report "Consumer Assessment of Health Plans in Delaware" distributed in April of 2000.

All three Delaware CAHPS project covered all Delaware residents (18 to64)-insured and uninsured. They were surveyed using the RDD method. The survey yielded a sample of 1,795 residents. Respondents without health insurance were also included in the survey so that data would be available to examine and compare the health care systems available to both the insured and the uninsured.

Analysis of this survey data resulted in three key studies: (1) A more detailed analysis of the uninsured[1]; (2) Applying geographic information system (GIS) analysis. Geographic Information System was used to examine if patterns of attitudes are correlated with different geographic areas (counties, zip codes, etc.) and spatially correlated with different measures of health and provider supply; and (3) Analysis of managed care vs. fee for service by applying Robert Blendon's/Kaiser Family Foundation's "degree of managed care" criteria. They will be looking to see if there are differences between "heavy" and "light" managed care.

Delaware plans to conduct CAHPS again in 2001.

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[1] Results are summarized in the April 2000 issue of Health Services Research "Uninsured and Unstably Insured: The Importance of Continuous Insurance Coverage" *Cathy Schoen and Catherine DesRoches*

Organization	Georgia Division of Medical Assistance
Contact	Jennifer Edwards, Georgia Health Policy Center E-mail: alhjne@langate.gsu.edu

The Georgia Health Policy Center conducted CAHPS for the Georgia Department of Medical Assistance in the year 2000. Georgia has also participated in the National CAHPS Benchmarking Database.

In the year 2000 project Georgia surveyed children in the Medicaid program. One goal of using CAHPS in this setting is to see if publicly insured children have access to care such as primary and preventative care, urgent care, specialty care, and dental care. Additionally, the survey sought to determine the experiences of children with special health care needs (CSHCN) differs between traditional Medicaid for children and the Georgia Children's Health Insurance Program (CHIP), called PeachCare.

Using the CAHPS 2.0 Survey for Medicaid managed care plans, the study selected a random, representative sample size of 1,585 children (1,084 Medicaid, 501 PeachCare). Using a mail with telephone follow-up method, the Medicaid response rate was 54 percent and the CHIP response rate was 70 percent. Data collection occurred between February and April 2000.

After controlling for race, parent education, child's age, and rural location, results for the two populations differed, suggesting that patient factors may effect responses and experiences. The study researched differences in care between the Medicaid and CHIP populations on five variables: child had a Primary Care physician, child had at least one doctor visit, child had little difficulty getting a dental appointment when needed, child saw a specialist when they needed one, and child did not have a big problem getting "needed care".

The analysis indicates that children with special needs have better access to primary care but worse access to specialized services (dental and other needed care). Although Medicaid and CHIP have identical program characteristics, CHIP clients have better access than Medicaid children, except for dental care.

Georgia Medicaid and CHIP programs will use these results to tailor future studies for children with special health care needs.

Organization HealthCare21

Contact Gaye Fortner
E-mail: gfortner@tds.net

HeathCare21 compiled a health plan performance report using CAHPS results from five health plans in Tennessee. HeathCare21 has also participated in the National CAHPS Benchmarking Database.

The plans surveyed were: Cariten Healthcare, CIGNA HealthCare of Tennessee, John Deere Health Care, The Initial Group, and United HealthCare of Tennessee, Inc. The purpose of the report is threefold: (1) Inform coalition members of quality of care indicators in health plans; (2) Provide information to health plans comparing performance; (3) Encourage continued communication between purchasers, plans, and providers regarding quality improvement.

The report was compiled using CAHPS data from the above five health plans and NCQA data from four other health plans in the state, in order to present the big picture. Data on the following plans was purchased from NCQA: Aetna US Healthcare, Prudential HealthCare (Memphis), Prudential HealthCare (Nashville), and Tennessee Health Care Network (A Blue Cross Blue Shield HMO/POS in Tennessee).

The report includes the summary results, detailed results presented as graphs, and accreditation status presented as excellent, commendable, accredited, provisional, and denied. Additionally, all results are compared to regional and national averages (using the National CAHPS Benchmarking Database benchmarks). Of the five health plans that sought accreditation, one received accredited status, one commendable, and two excellent.

The report, "Health Plan Report Card", is available to members of HealthCare21..

Organization Maryland Health Care Commission (MHCC)

Contact Pamela Cheetham
E-mail: pcheetham@mhcc.state.md.us

In 2000, the Maryland Health Care Commission, MHCC, (formerly called the Maryland Health Care Access and Cost Commission) conducted the CAHPS 2.0H adult survey. Fifteen commercial HMOs that are required to submit performance data to the Commission participated in the study. MHCC has also participated in the National CAHPS Benchmarking Database.

The results of the CAHPS survey were included, along with HEDIS data, in the series of reports this Commission publishes each year for several different audiences within the State of Maryland. *Comparing the Quality of Maryland HMOs: A Guide for Consumers* is the publication that is disseminated most widely to assist people in making decisions about which health plan to choose. This year, for the first time in the guide for consumers, the Commission recognized health plans that reported HEDIS rates that were better than average for the third consecutive year. The plans (five of the fifteen) with better than average showings were labeled "Star Performers". The criteria of three years, excluded CAHPS measures, since CAHPS has been used in Maryland for only two years. In 2001, the Commission intends to include above average performance in CAHPS survey measures as part of the definition of "Star Performers". In addition to printing forty thousand booklets, the publication is posted (as a .pdf document) on the Commission's web site at http://www.mhcc.state.md.us/hmo/_hmo.htm

Also available online is an interactive version of the guide for consumers which allows viewers to compare the performance of as many or as few of the 15 HMOs as are of interest to the viewer. The interactive version of the guide has generated interest among businesses, which can create a custom version of the HMO guide for consumers featuring the HMOs that they offer to their employees. After creating their customized report online, businesses can print and distribute to their employees a guide to the HMOs available to them.

In 2000, for the third year, The Maryland Health Care Commission created and printed a customized version of the consumer guide for the 100,000 State of Maryland employees. *Comparing the Quality of Maryland HMOs: A Guide for State Employees* was distributed, along with health benefit information, during fall open enrollment.

The 2000 Comprehensive Performance Report: Commercial Health Maintenance Organizations in Maryland is a compendium of more HEDIS and CAHPS data for each of the 15 commercial HMOs than can be included in the guide for consumers. It is intended primarily for use by health policymakers, the health plans, and the Commission. The 2000 publication compares each plan's performance for each measure with the plan's own performance in 1999 and 1998 (for HEDIS) and compares each plan's performance to the average for all commercial HMOs that reported each of the measure in 2000, 1999, and 1998 (for HEDIS). The comprehensive report is also posted on the Commission's web site.

The final publication in the 2000 series of HMO reports, *The 2000 Policy Report*, will be released in early 2001. The intended audience is legislators and their staffs who need a broad view of how commercial HMOs in this state have performed over time and how their performance, in aggregate, compares to the performance of commercial HMOs in the mid-Atlantic region and throughout the United States. This report will be posted on the MHCC web site. Until it is posted, the 1999 Policy Report will remain online.

Organization	The Office of Personnel Management (OPM)
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The Office of Personnel Management conducts an annual CAHPS survey of plans participating in the Federal Employees Health Benefits Program. The year 2000 project was occurred between October 1999 and November 2000, with data collection occurring between February and June 2000. OPM has also participated in the National CAHPS Benchmarking Database.

The survey covered 264 plans (240 HMOs, 11 POS' and 12 FFS/PPO's) in 42 states, Puerto Rico, Guam, and the District of Columbia. The eight states not currently covered by the OPM survey are: Alaska, Arkansas, Maine, Nebraska, New Hampshire, South Dakota, West Virginia, and Wyoming. The survey samples 850 adults in each of the 264 plans. Using a mail with telephone follow-up data collection method OPM achieved an overall response rate of 53.2 percent. Individually, the response rate for HMO/POS plans was 52.4 percent and 70.8 percent for FFS/PPO plans.

The survey results were reported in the FEHB guide and posted on the OPM web site (www.opm.gov/insure/health/about/quality.htm). .The website provides summary and detailed reports and ratings for each of the content areas. The site informs readers how CAHPS results can aid in decision-making and how CAHPS relates to accreditation.

Survey results are provided to help active and retired Federal employees make health plan choices during open enrollment. Participating health plans are encouraged to use the survey data to improve quality of services they provide. OPM uses this data to manage and evaluate the more than 250 FEHB health plans and to compare and track plans' performance over time. In the future OPM plans to use the survey results and other quality measurement data, such as accreditation, to develop individual health plan performance profiles or report cards.

Organization The Oklahoma Health Care Authority (OHCA)

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The Oklahoma Health Care Authority (OHCA) has used the CAHPS Medicaid surveys to measure patient experience in SoonerCare Medicaid managed care programs for both adults and children. OHCA has been conducting CAHPS since {INSERT YEAR}. OHCA has also participated in the National CAHPS Benchmarking Database.

Beginning in 1999 the Medicaid health plans started conducted CAHPS surveys to meet NCQA reporting requirements. In order to maximize resources and minimize overlap OHCA coordinated the survey with the plans. On completing data collection the plans now submit a copy of their data file to OHCA. .OHCA continues conduct the CAHPS survey for the partially capitated rural SoonerCare Choice program.

Results from the first two years of administration indicated a modest, but sustained increase in levels of satisfaction with significant differences in improvement in some areas. The results are reported in an article published in the state Medical Association journal

In addition to the CAHPS Medicaid surveys, OHCA has been surveying other vulnerable populations in the state-children with special health care needs, children with behavioral conditions, and Medicaid SSI participants. CAHPS for Children with Special Health Care Needs has been administered for two years, with 1999 results recently released. A particularly interesting note is the relatively high response rate of this population in comparison to other populations surveyed. In 2001 OHCA is considering adapting the behavioral health care CAHPS survey ECHO-Experience with Health Care Outcomes) to survey children in the Medicaid program. Another interesting study is the use of CAHPS to evaluate the SSI managed care program. The SSI managed care program was implemented in two phases- the urban fully capitated program was implemented first followed by the rural partially capitated managed care program. The evaluation plan used a pre- post model, where the population who were to enroll in the rural program was surveyed before enrollment (and will be surveyed again after 6 months in the program) and the population enrolled in the urban program were surveyed after they were enrolled at least 6 months in the program. The control group for the study was the fee-for-service adult Medicaid population.

Comparison of data from fee for service SSI adult CAHPS survey and the urban fully capitated SSI adult CAHPS survey indicate a generally higher level of satisfaction with the managed care program. Comparisons will also be made with the partially capitated SSI adult population, when those results are available.

Organization Washington State Department of Social and Health Services
Medical Assistance Administration (MAA)

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Washington State Medical Assistance Administration (MAA) has been conducting CAHPS annually for the last four years. The main goal of performing CAHPS is to provide timely information to assist clients in choosing a health plan. Washington has also participated in the National CAHPS Benchmarking Database.

In 2000 Washington was selected as a filed test site of the CAHPS Children with Special Health Care Need survey. The survey is meant to identify and learn about the quality of care received by children with chronic or special health care needs (CSHCN). The survey includes a new set of supplemental questions, a detailed screener and the CAHPS core questions. The new supplemental topics include: getting prescription medicines, getting specialized services, getting family support, and coordination of care. The results of this initiative will be used to inform parents/guardians of how Medicaid health plans in Washington State provide care for children with special health care needs.

This survey was conducted during April - August 2000 covering 9 health plans, all HMOs, and fee-for-service,. Surveys were filled out for 15,362 children age 13 or younger in Medicaid Managed Care and 1,469 children 13 or younger for fee-for-service Medicaid. A mail with telephone follow-up method was used to contact parents/guardians of these children. . The over all adjusted response rate[2] was 57.4 percent for Medicaid Managed Care and 62.78 percent for Fee for Service.

Survey results were presented in a stakeholder report and a consumer report (100,000 copies of the client brochure and the stakeholder report were printed). The stakeholder report went to advocacy groups, health plans, the Department of Health, and other interested state agencies. The consumer report, which uses stars to facilitate plan comparisons, went to all new members, displaced members, community service organizations, client outreach workers, and advocacy groups. .

Washington State plans to perform both adult and children CAHPS surveys with additional questions on pregnancy for an internal project, in the coming year. The Promoting Health Development

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[2] Adjusted response rate =complete surveys/total eligible sample

Survey (infants from 3months to 4 years) is being done for a second time this year and will be finalized and reported on in 2001.

Organization Health Care Financing Administration

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In order to fulfill a congressional mandate, HCFA has been conducting an annual CAHPS survey of its managed care beneficiaries. In fall 2000, the fourth year of CAHPS data collection for managed care enrollees, HCFA started up two additional CAHPS surveys for the managed care disenrollees and fee-for-service beneficiaries.

Managed Care Enrollee Survey

In 2000-2001, year 4 of the managed care project, the survey will analyze the delivery of Medicare managed care services for as many as 225,000 English-, and Spanish-speaking Medicare beneficiaries enrolled in approximately 280 Medicare managed care plans across the country. Data collection for year 4 is close to completion. Data has been collected through administering two mail surveys, including a telephone follow-up to nonrespondents. This data collection methodology yielded a response rate of 75.3 percent in 1997 and 80.98 percent in 1998, 82.0 percent in 1999. The response rate for the current year is 82.73 percent.

Results from year 3 are available through the Medicare Health Plan Compare at www.medicare.gov and the *Medicare and You* handbook. Results from year 3 are also available by calling 1-800-MEDICARE. Results are also reported to the individual health plans, PROs and HCFA regional offices in full printed reports.

Since the Internet is the one of the media through which CAHPS results are presented, HCFA is conducting a number of Internet usability studies to help them fine-tune the site. Currently, HCFA is conducting computer lab sessions, focus groups, and think-aloud sessions to obtain feedback on Medicare Health Plan Compare.

Managed Care Disenrollee Survey

The disenrollee survey is divided into two separate survey efforts. One is focusing on the reasons for disenrollment, while the other obtains an assessment from a beneficiary about their former health plan. The reasons survey is conducted on a quarterly basis and the assessment survey is conducted

annually. The reasons survey began in May 2000; this survey effort covers close to 100,000 beneficiaries over a year period in approximately 280 plans. The assessment survey covers approximately 31,000 beneficiaries in approximately 280 health plans. Data collection for year 1 for the assessment survey will be completed by February 2001. The disenrollee survey followed the same data collection protocol- two mail surveys, including a telephone follow-up to nonrespondents.

Results from the survey will be available in 2001 through the Medicare Health Plan Compare at www.medicare.gov. Results from the survey are also available by calling 1-800-MEDICARE. Results will also reported to the individual health plans, PROs and HCFA regional offices in full printed reports.

Fee-For-Service Survey

The fee-for-service survey covered approximately 168,000 beneficiaries in 280 geographic locations. The data collection protocol was similar to the managed care surveys-mail with phone follow-up. Data collection for year 1 will be completed by February 2001.

Results from the survey will be available in 2001 through the Medicare Health Plan Compare at www.medicare.gov. Results from the survey are also available by calling 1-800-MEDICARE. Results will also be reported to the individual health plans, PROs and HCFA regional offices in full printed reports.

Integrating CAHPS Information in Medicare Quality Improvement Initiatives

HCFA recently sponsored a study to determine the feasibility of integrating CAHPS data within initiatives for improving quality of services in the Medicare program. The project identified areas where use of specific CAHPS measures might assist in targeting and monitoring clinical improvement in continuing efforts to enhance smoking cessation counseling by physicians, and increasing the rates of both flu and pneumococcal vaccination of beneficiaries. The initial project has also led to a second project currently under development, which will attempt to link several CAHPS experience and satisfaction measures with measures of beneficiaries clinical experiences from other Medicare data sets. Results of this study may be used to enhance efforts to improve both preventive care and treatment of beneficiaries with specific health care needs.

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